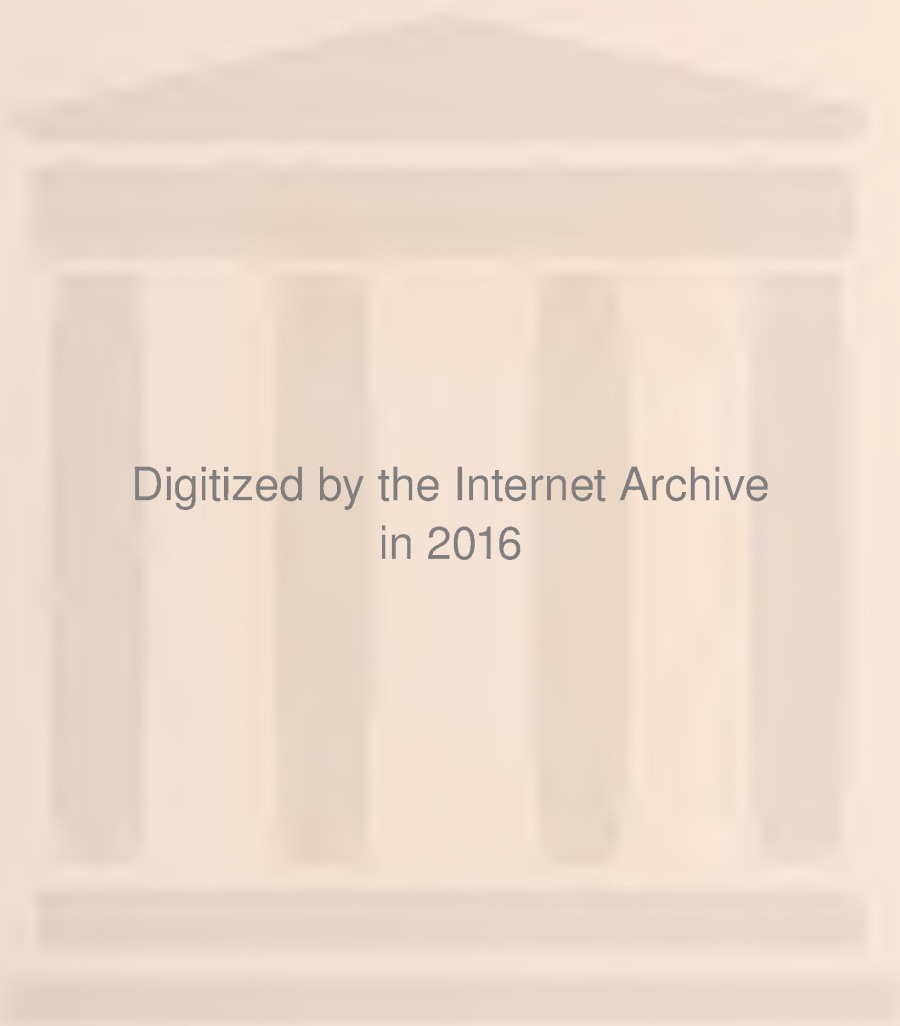
The New York
Academy of Medicine



Gift from the
Publisher


Digitized by the Internet Archive
in 2016

https://archive.org/details/journalofmississ17unse

BALCONY

AMERICAN REVOLUTION BICENTENNIAL 1776-1976

JOURNAL OF THE Mississippi STATE MEDICAL ASSOCIATION

JANUARY 1976

BECOTIN®
Vitamin B Complex

BECOTIN® with VITAMIN C
Vitamin B Complex with Vitamin C

BECOTIN®-T
Vitamin B Complex with Vitamin C, Therapeutic

MI-CEBRIN®
Vitamins-Minerals

MI-CEBRIN T®
Vitamin-Minerals Therapeutic

AND A WIDE VARIETY OF OTHER PHARMACEUTICALS

DISTA

DISTA PRODUCTS COMPANY
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

400944

This Month . . . Surgical Treatment of Vertigo, Peritoneovenous Shunting for Ascites, T-Tube Stone Extraction

M.S.M.A.

Both often

LIBRARY

MAR 9 1981

NEW YORK ACADEMY
OF MEDICINE



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

TO COMPLETE YOUR HEALTH INSURANCE PICTURE, MSMA OFFERS ITS NEW COMPLETE HEALTH INSURANCE PACKAGE:

NEW MAJOR MEDICAL PLAN

Covers 80% of your eligible expenses after you satisfy your deductible amount. Choice of deductibles available. Pays expenses in and out of the hospital!

NEW HOSPITAL MONEY PLAN®

Pays a daily benefit for each day you spend in the hospital because of an accident or illness. Acceptance is GUARANTEED! Pays the benefits directly to *you*!

NEW EXCESS MAJOR MEDICAL PLAN

Picks up where basic insurance programs leave off. Pays 100% of eligible expenses in or out of the hospital—up to $250,000 maximum. And, premiums are LOW! Acceptance is GUARANTEED!

A complete health insurance picture is probably one of the most important items you can provide for your family's financial well-being. To help you combat the rising cost of hospital and medical care, MSMA has entirely revamped its health insurance program to give you the most complete and comprehensive program available . . . and at a low price all can appreciate. Find out more. Mail the coupon below for more information:

THE MSMA INSURANCE PROGRAMS ARE UNDERWRITTEN BY:



CONTINENTAL CASUALTY Co.
ASSOCIATION GROUP DIVISION
Chicago, IL 60685

a division of CNA/insurance

Please send me more details on the NEW MSMA insurance programs:

☐ MSMA MAJOR MEDICAL PLAN ☐ MSMA HOSPITAL MONEY PLAN ☐ MSMA EXCESS MAJOR MEDICAL PLAN

NAME_____

ADDRESS_____

CITY_____

STATE_____ ZIP CODE_____

MAIL TO: Thomas Yates & Co., MSMA Insurance Administrators P.O. Box 1054, Jackson, Mississippi 39205

Volume XVII
Number 1
January 1976



JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

• EDITOR
W. MONCURE DABNEY, M.D.

• ASSOCIATE EDITORS
GEORGE H. MARTIN, M.D.
MYRON W. LOCKEY, M.D.

• MANAGING EDITOR
NOLA GIBSON

• PUBLICATIONS COMMITTEE
LAWRENCE W. LONG, M.D.
Chairman
FRANK L. BUTLER, JR., M.D.
T. A. BAINES, M.D.
and the editors

• THE ASSOCIATION
JACK A. ATKINSON, M.D.
President
LYNE S. GAMBLE, M.D.
President-Elect
JAMES P. SPELL, M.D.
Secretary-Treasurer
C. D. TAYLOR, JR., M.D.
Speaker
R. F. TRIPLETT, M.D.
Vice Speaker
CHARLES L. MATHEWS
Executive Secretary
H. CODY HARRELL
Assistant Executive Secretary

THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION is owned and published monthly by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, $15.00 per annum; $2 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

CONTENTS

ORIGINAL PAPERS

Surgical Treatment for Vertigo—Sound or Fury? 1 GALE GARDNER, M.D. Memphis, Tenn.

Problems in Abdominal Surgery 1. Peritoneovenous Shunting for Intractable Ascites 5 WILLIAM O. BARNETT, M.D. Jackson, Miss.

SPECIAL ARTICLES

Radiologic Seminar CLVIII: Trans T-Tube Extraction of Retained Biliary Stones 8 JEFF HODGES, M.D. Pascagoula, Miss.

A History of Medical Publications in Mississippi 10 NOLA GIBSON Jackson, Miss.

EDITORIALS

The Past, Present and Future of Emergency Medical Care in the State of Mississippi 15 W. BRIGGS HOPSON, JR., M.D. Vicksburg, Miss.

The Bicentennial 16 NOLA GIBSON Jackson, Miss.

THIS MONTH

The President Speaking 14 "Thoughts on the Health Care Scene"

This Month 21 MSMA Board Holds Fall Meeting

Copyright 1976, Mississippi State Medical Association

Internists Study Immunology in Florida

The American College of Physicians (ACP) will sponsor a three-day postgraduate course entitled "Immunological Mechanisms of Disease" on Feb. 18-20, 1976, in Gainesville, Fla. The course, held in conjunction with the University of Florida College of Medicine, will take place at the Hilton Hotel.

The course will review the progress made in basic immunology and apply this to the understanding of the pathogenesis, diagnosis, and therapy of diseases. Topics of discussion will include the role of immunological mechanisms of infectious diseases, diagnosis, and therapy; diagnosis and immunotherapy of cancer patients; diagnosis and therapy of allergic, "autoimmune," and immunodeficiency disorders; and, control of transplant rejection.

The American College of Physicians postgraduate courses have been approved by the American Medical Association Advisory Committee on Continuing Medical Education, and may be used to fulfill Category 1 requirements for the AMA Physicians' Recognition Award.

Director of the Gainesville postgraduate course is Dr. L. E. Cluff, and Dr. R. H. Waldman is co-director.

Hair Transplant Symposium Set

The American Society for Dermatologic Surgery, The American Academy of Facial Plastic and Reconstructive Surgery, and The American Association of Cosmetic Surgeons are co-sponsoring this conference designed to offer an opportunity for the exchange of ideas among various disciplines and to present the latest advances in techniques on hair transplantation.

It will be held Feb. 13-14, 1976, at the Stough Dermatology and Cutaneous Surgery Clinic, P. A., Doctors Park, Hot Springs, Ark. 71901. Attendance will be limited.

Faculty will include dermatologists, otolaryngologists, regional and general plastic surgeons.

For further information, contact: Dr. D. B. Stough, III, Program Director. (Address as listed above.)

helping you change things for the better

Canton Exchange Bank

A FULL SERVICE BANK

"Your Account Handled in Strict Confidence"

Each depositor insured to $40,000

Branch Offices

Canton East Branch
Bank Of Madison
Bank Of Ridgeland

FDIC

Federal Deposit Insurance Corporation

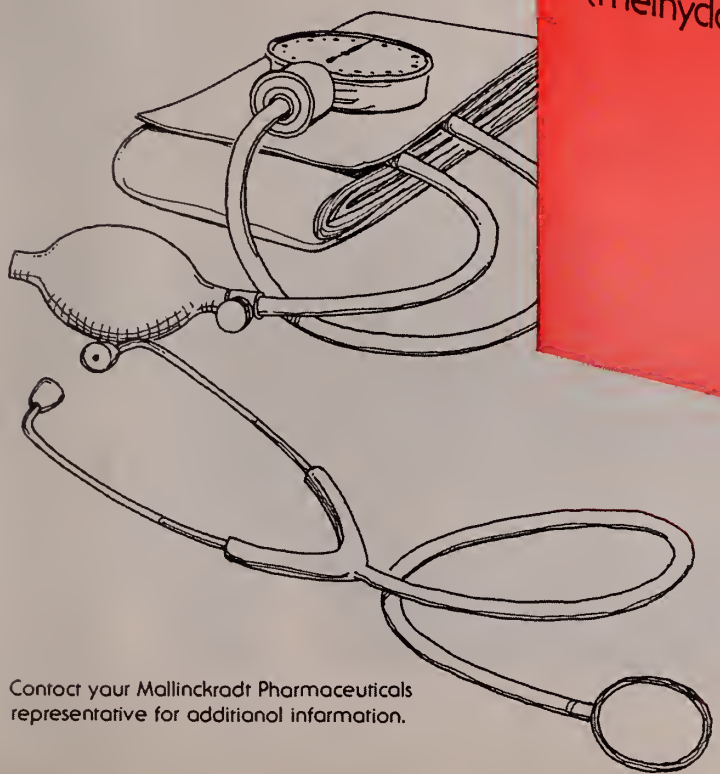
"Our 95th Year Of Continuous Service"

3NY1 312 BB
QUALITY CONTROL MARK
2835

Mallinckrodt Pharmaceuticals

takes
the basic
tools concept
one step
further





*As tannate salts, equivalent to 260 Carotid Sinus Reflex Units.

Contact your Mallinckrodt Pharmaceuticals representative for additional information.

Mallinckrodt®
Pharmaceuticals
Linking Chemistry to Medicine®

Mallinckrodt, Inc.
St. Louis, Mo. 63147

Not all your Representatives are at the Capitol.

Your Blue Cross and Blue Shield Professional and Provider Relations Representatives are busy covering the state to answer questions and help solve problems for physicians and other providers of health care. There's one specifically assigned to your area. Get to know him, and tell him how he can help you. Like your Representative at the Capitol, serving you is his job.



® Registered Marks Blue Cross Association
® Registered Service Marks of the National Association of Blue Shield Plans

Blue Cross®
Blue Shield®
of Mississippi

530 E. Woodrow Wilson Ave.
P. O. Box 1043
Jackson, Miss. 39205
Telephone 982-0010

Area 6
All share responsiblity for Jackson

Area 3
Ron Hodges

Area 2
Roger Alford

Area 4
Mark
Matthews

Area 1
Marvin
Earnheart

Area 5
Ralph
Burroughs

Manager,
Medical
Assistant
Liaison
Warren
Edwards

Manager
Lowell "Bud"
Peters



NEWSLETTER

January 1976

Dear Doctor:

The Civilian Health and Medical Program (CHAMPUS) has announced that effective January 1976 it will begin paying the 75th percentile of physicians' customary and prevailing charges in Mississippi and other states. The decision was announced as a further reduction in CHAMPUS benefits resulting from congressional cuts in funding for the program which had been covering customary charges submitted by 90 per cent of Mississippi physicians.

> CHAMPUS was implemented in 1956 as a program of hospital and medical benefits for dependents of members of the military services and was later expanded to include retired members of the military services and their families as well as disabled veterans. Benefits were also expanded.

MSMA and other Mississippi health professional associations will sponsor a "Mississippi Health Care Forum" this spring. The forum will be a one day meeting for Mississippi health care leaders to meet, hear, and discuss current health issues. MSMA president, Dr. Jack A. Atkinson of Brookhaven, cited the need for Mississippi's health professionals to get together on matters of mutual interest.

In California, doctors -- faced on January 1 with increases in malpractice insurance premiums up to five times what they now pay -- are leaving the state, retiring early or looking for salaried positions where their insurance is paid for them. Dr. Joseph Boyle, speaker of the CMA's House of Delegates, said surveys show as many as 45 per cent of the state's 42,000 doctors will be lost.

Foreign medical graduates in the U.S. are grossly over-counted, according to Dr. Rosemary Stevens of Yale in a Science magazine article. The actual number entering the country between 1965-73 was 10,000 less than the 66,757 reported and projected. Changes in "citizenship" status, rather than new immigrations, ran up the total, she said, adding that the wrong numbers created general backlash.

Using a low average per day cost of $80, Miss. hospitals still lost over $1,755,000 for the 1974-75 fiscal year under the indigent care program operated by the Miss. Hospital Commission. During this period, the commission reimbursed participating hospitals at the rate of $12.50 per day for 3,700 patients who were provided 26,000 days of care. Total payment approximated $325,000.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor



What should a girl, unwed and in need of help do, when she finds herself pregnant?

If you will refer her to us—the Volunteers of America—we will make certain that she is well cared for and her baby is given the opportunity for a healthy, happy life. Our services include full pre-natal, delivery and post-natal care in modern, attractive surroundings—counseling by trained and compassionate professionals and placement of the infant through adoption, if desired.

For a confidential discussion, phone Mrs. O'Brien of the Volunteers of America in New Orleans (504) 891-7713.

South Central Blood Banks Meet

The 18th Annual Meeting of the South Central Association of Blood Banks will be held Feb. 18-20, 1976, at the Astroworld Hotel, Houston, Tex.

For additional information, contact: (Mrs.) Floy Bleker, Executive Secretary, South Central Association of Blood Banks, 4300 North Lamar Boulevard, Austin, Tex. 78756.

Respiratory Disease Course Scheduled

New York University Post-Graduate Medical School will present a three-day course on "Current Topics in Respiratory Disease," Jan. 22-24, 1976.

The course is designed for internists and family physicians who wish a detailed and comprehensive review of some of the more commonly encountered respiratory diseases. Special emphasis will be placed on newer concepts of disease mechanisms, diagnosis and effective patient management in the office and hospital setting. The course material is particularly appropriate for physicians preparing for certification or recertification in medicine, as well as those who wish to update their clinical skills in pulmonary diseases. Instruction will be by lectures, case presentations and panel discussions with ample time allotted for free interchange between physicians and faculty. Lecture abstracts and annotated references will be provided.

Subjects include "Pulmonary Infections," "Chronic Obstructive Pulmonary Disease," "Asthma and Hypersensitivity Pneumonitis," "Acute Respiratory Failure" and "Physiologic Derangements in Lung Disease."

Course directors are Dr. H. William Harris, professor of clinical medicine, and Dr. John H. McClement, professor of medicine.

This course is approved for 17 hours credit in Category I for the Physician's Recognition Award of the American Medical Association.

A tuition fee of $185 is payable when submitting application.

Applications and a detailed brochure of the course may be obtained from Office of the Associate Dean, New York University Post-Graduate Medical School, 550 First Avenue, New York, N. Y. 10016; or telephone (212) 679-3200, ext. 4037.

Inter-American Symposium On Medicine Set

An Inter-American Symposium on Internal Medicine, sponsored by the Department of Medicine, The University of Oklahoma in association with the National Academy of Medicine of Mexico, will be held at the Centro Medico Nacional of the Instituto Mexicano Del Seguro Social in Mexico City, Mexico, Jan. 12-15, 1976.

The theme of the course will be "What's New in Diagnosis and Therapy." The faculty include the members of the Department of Medicine, The University of Oklahoma and renowned educators from Mexico and Canada. Subject material will feature discussions in gastroenterology, cardiovascular, renal, pulmonary, hematology-oncology, endocrinology and infectious diseases.

For further details on the course, group air fares, hotel accommodations and post-symposium tours contact: Drs. James F. Hammarsten and Solomon Papper, co-directors, The University of Oklahoma Health Sciences Center, College of Medicine, Department of Medicine, Post Office Box 26901, Oklahoma City, Okla. 73190.

Adolescent Care Unit

350 Crossgates Blvd.
P. O. Box 738
Brandon, Mississippi 39042
(601) 982-8151

A private, in-patient intensive psychiatric treatment unit for a wide range of nervous, emotional, mental and personality disorders. Accredited and Licensed. Academic programs maintained by Educational Psychologist. The Adolescent Care Unit is situated in a General hospital less than two miles from the Jackson Municipal Airport.

C. Mims Edwards, M.D.,
Attending Psychiatrist
Barbara Goff, M.D.,
Consulting Psychiatrist

PRINTING — OFFICE SUPPLIES

EQUIPMENT — FURNITURE



Premier Printing Company

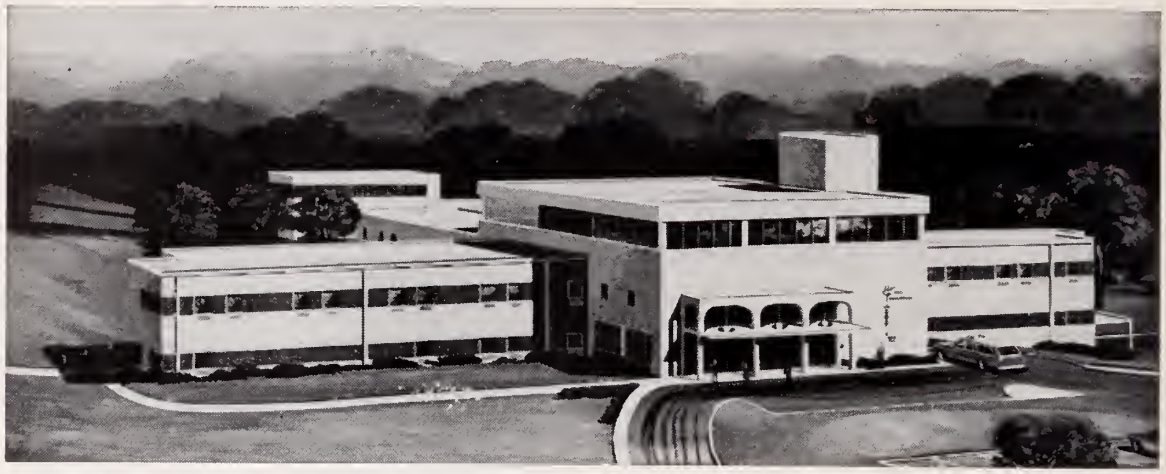
2485 West Capitol Jackson, Mississippi
Phone 352-4091

it's the real thing

Enjoy Coca-Cola Trade-mark ®

70-37

Mississippi Council of Coca-Cola Bottlers



HILL CREST HOSPITAL

For Intensive Treatment of Psychiatric Disorders

This 101-bed non-governmental psychiatric hospital provides modern facilities for diagnosis and treatment of patients with all degrees of illness, including those who show severely disturbed behavior. Alcoholic and drug abuse patients are also accepted.

In addition to care by psychiatrists and by consultants in all medical specialties, the treatment program includes occupational, recreational, and physical therapy, social services, and tutoring. Emphasis is on short-term, intensive treatment of voluntary patients.

Hill Crest is a member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Alabama Hospital Association, Birmingham Regional Hospital Council.

Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved. Blue Cross Participating Hospital.

MEDICAL DIRECTOR:

James K. Ward, M.D.

ADMINISTRATOR:

Robert V. Sanders

HILL CREST HOSPITAL

HILL CREST FOUNDATION, INC.

6869 Fifth Avenue South **Birmingham, Alabama 35212**

PHONE: 205-836-7201

DATELINE

Doctors Provide Service for Town

Pascagoula, MS - The Singing River Medical Society has started an information service for citizens that will be helpful to families looking for a physician. The society is sponsoring an answering service to help link up patients and doctors. The telephone service will be staffed by a registered nurse to provide the names of those physicians who offer the kind of treatment required; it is an information service only, not a referral or recommendation service.

Public Spending Increases

Washington, D.C. - Health care spending in the U.S. reached $118.5 billion in fiscal 1975, with public spending increasing at almost twice the rate of the previous year, according to a Social Security study. The $118.5 billion health care bill represented a 13.9 per cent increase over the $104 billion spent in fiscal 1974. Public spending increased by 22.2 per cent, compared with a 12.3 per cent increase in 1974. Private spending was 57.8 per cent of the total health care expenditures.

Hospitals Form Insurance Companies

Chicago, IL - Five state hospital associations are forming their own captive insurance companies, according to the Medical Liability Commission Commentary. Following a decision by Employers Insurance of Wausau to begin nonrenewal of hospital medical liability policies by Jan. 1, 1976, and to cease renewing all policies by Aug. 1, the Pennsylvania Hospital Association has moved to set up a captive insurance company. Missouri, California, Tennessee and Texas have taken similar actions.

Florida Program Aims at Prevention

Miami, Fla. - The Dade County, Fla., school system has funded a $1.2 million, multi-faceted prevention program in the schools which aims at providing students, parents, and other community members with skills for resolving substance abuse and other life problems before they reach crisis proportions. The effort focuses on clarifying values, attitudes, and feelings about alcohol and drugs as well as providing facts about their use and misuse.

Jail Program Gains Wide Acceptance

Chicago, IL - More than 30 state medical societies have applied to take part in the AMA's project to improve medical care in jails. Under the terms of the AMA's grant from the Law Enforcement Administration, only six states can participate in the pilot program which will study current medical care standards in county and municipal jails, then draw up a set of minimum standards. Program will be supervised by newly-appointed AMA advisory committee.

consider the effect on coexisting diabetes when you prescribe a vasodilator*



(POSTERIOR VIEW OF PANCREAS)

no interference in the management of the diabetic patient has been reported with

VASODILAN®
(ISOXSUPRINE HCl)

TABLETS, 20 mg.

the compatible vasodilator

Mead Johnson LABORATORIES

© 1976 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL-54117

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

Counsel to Authors

THE JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, Miss. 39216, in original and at least one duplicate copy. They must be typewritten double spaced on 8½ by 11-inch white bond paper with a standard typewriter.

The author is responsible for all statements made in his work, including changes made by the manuscript editor. Manuscripts are received with the understanding that they are not under simultaneous consideration by any other publication and have not been previously published. All manuscripts will be acknowledged, and while those rejected are generally returned to the author, the JOURNAL is not responsible in event of loss. Manuscripts accepted for publication become the property of the JOURNAL and are copyrighted by the association when published. They may not be published elsewhere without written release and permission from both the JOURNAL and the author.

All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10, but when justified to the Editors, additional references will be considered for publication. Each will be critically examined, and only valid, primary references will be published. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus,* volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made after proof sheets are received by the JOURNAL.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for illustration engravings not exceeding four column inches per printed page.

Illustrations must be numbered and cited in the text. Legends, not exceeding 40 words and preferably shorter, must accompany each illustration, typed double spaced on separate sheets. The following information should appear on a gummed label affixed to the back of each illustration: Figure number, manuscript title, author's name, and arrow indicating top of the illustration.

In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

A thesis summary of 75 to 100 words must accompany each manuscript separately from the text.

Reprints may be obtained at cost plus shipping charges from the association and should be ordered prior to publication. The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. —*The Editors.*



LUFYLLIN® (dyphylline)

Before prescribing, please review complete product information, a summary of which follows:

Indications: For relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

Precautions: Exercise caution with use in the presence of severe cardiac disease, renal or hepatic malfunction, glaucoma, hyperthyroidism, peptic ulcer, and concomitant use of other xanthine-containing formulations or other CNS stimulating drugs.

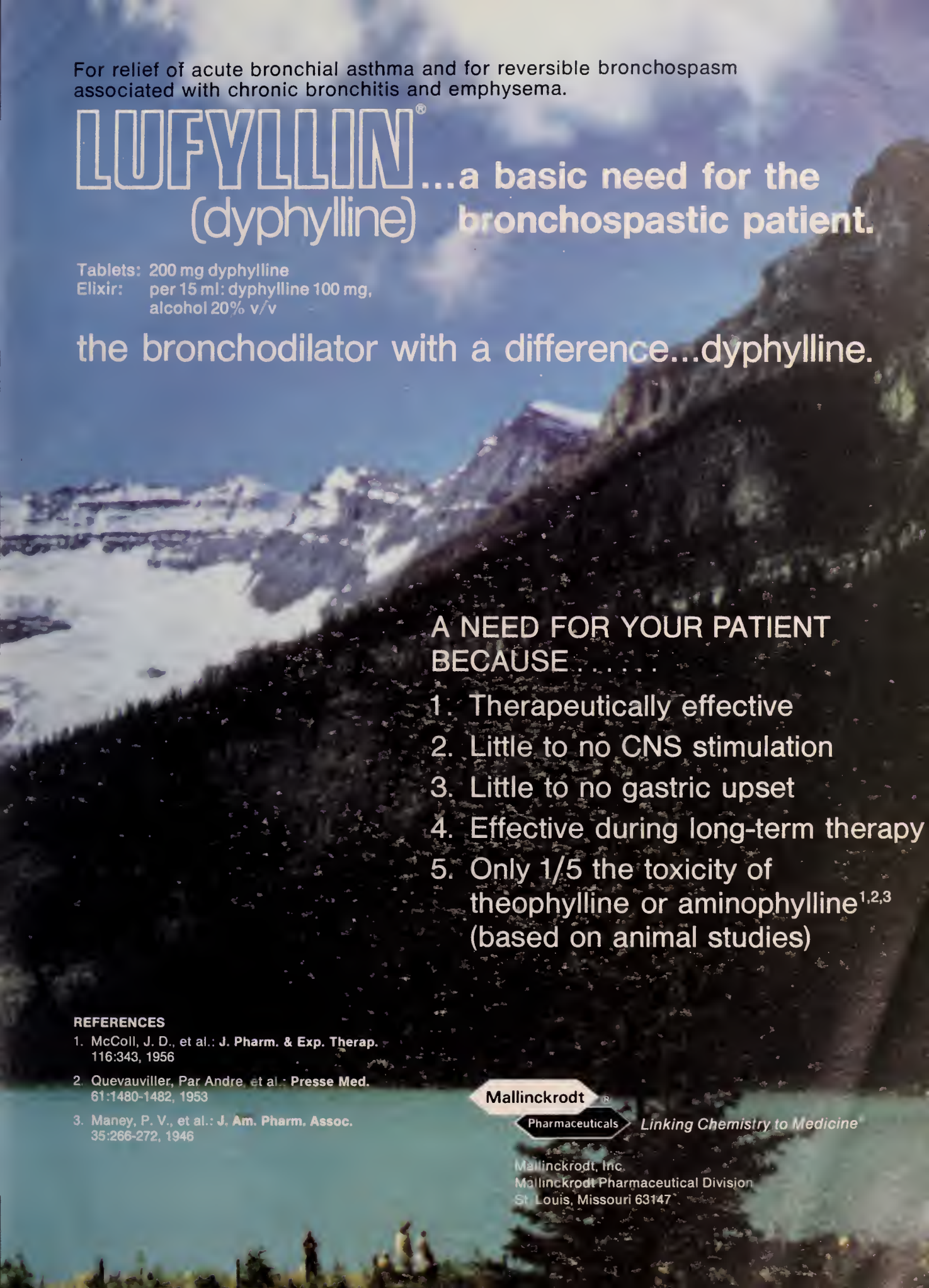
Adverse Reactions: May cause nausea, headache, cardiac palpitation and CNS stimulation. Postprandial administration may help to avoid gastric discomfort.

How Supplied:

LUFYLLIN, 200 mg., Tablets: NDC 19-R521-92, bottle of 100; NDC 19-R521-97, bottle of 1000.

LUFYLLIN Elixir: NDC 19-R515-68, pint bottle; NDC 19-R515-69, gallon bottle.

LUFYLLIN Injection: NDC 19-R537-T2, box of 25 x 2 ml. ampuls.


For relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.
LUFYLLIN®
(dyphylline)
...a basic need for the bronchospastic patient.
Tablets: 200 mg dyphylline
Elixir: per 15 ml: dyphylline 100 mg, alcohol 20% v/v
the bronchodilator with a difference...dyphylline.
A NEED FOR YOUR PATIENT BECAUSE . . . . .
1. Therapeutically effective
2. Little to no CNS stimulation
3. Little to no gastric upset
4. Effective during long-term therapy
5. Only 1/5 the toxicity of theophylline or aminophylline[1,2,3] (based on animal studies)
REFERENCES
1. McColl, J. D., et al.: J. Pharm. & Exp. Therap. 116:343, 1956
2. Quevauviller, Par Andre, et al.: Presse Med. 61:1480-1482, 1953
3. Maney, P. V., et al.: J. Am. Pharm. Assoc. 35:266-272, 1946
Mallinckrodt®
Pharmaceuticals
Linking Chemistry to Medicine
Mallinckrodt, Inc.
Mallinckrodt Pharmaceutical Division
St. Louis, Missouri 63147

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Clinical Convention, Nov. 29-Dec. 4, Honolulu. Annual Convention, June 26-July 1, Dallas. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

La.-Miss. O. and O. Society, May 27-29, 1976, Point Clear, Ala. Arthur Hays, M.D., Secy., 3017 13th St., Gulfport 39501.

Southeastern Surgical Congress, 44th Annual Assembly, Mar. 14-18, 1976, New Orleans. A. H. Letton, Secy., 315 Blvd. N.E., Atlanta, Ga. 30312.

STATE AND LOCAL

Mississippi Academy of Family Physicians, Annual Meeting, July 7-10, 1976, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 108th Annual Session, May 3-6, 1976, Jackson. Charles L. Mathews, Executive Secy., 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Smith, Yazoo.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson. 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Gerald A. Smith, Secy., P.O. Box 128, Sumner 38957. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. A. K. Martinolich, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. George L. Arrington, Jr., 1413 22nd Ave., Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, April, June, August, October, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., Jefferson Davis Memorial Hospital, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. D. Stanley Hartness, Jr., Secy., 314 Adams St., Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Lee H. Rogers, Secy., 610 Brunson Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, October. Cherie Friedman, Secy., 4255 5th Ave., Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. G. O. Spencer Jr., Secy., 425 Hospital Dr., Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, May, July, September, November. Dewey Lane, Secy., Doctors Plaza, Suite 206, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. John L. Smith, Secy., No. 1 Medical Blvd., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m. Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Pulmonary Course Set for New Orleans

The three annual national and international postgraduate courses in pulmonary diseases held in New Orleans each winter will be consolidated into a single week and called "Supercourse" starting Feb. 16, 1976, according to the American Thoracic Society.

The 12th Annual International Postgraduate Course for Physicians on "Pulmonary Function in Health and Disease," the 5th Annual National Postgraduate Course for Physicians on "Pediatric Pulmonary Disease," and the 8th Annual Course on "Newer Concepts of Care for Patients with Respiratory Disease" for the medical care team, will take place simultaneously and be held at Braniff Place (hotel) in New Orleans.

The Respiratory Care Course will open Feb. 16, followed by the Pulmonary Function Course on Feb. 17, and the Pediatric Pulmonary Course on Feb. 18.

The three entities will be sustained as distinct programs, but will be packaged under the title "New Orleans Mardi Gras Supercourse." According to W. Findley Raymond, ATSL administrator, the dates fall two weeks prior to Mardi Gras and registrants will have the option of remaining in New Orleans for the weekend of Feb. 20-22, to partake of the New Orleans' Carnival season's first street parades.

Course tuition will be $150 for any of the individual entities within the Supercourse, and registrants may move from one course's session or lecture to another as the week progresses if they choose to do so. No waiver of tuition will be involved with the exception of residents and fellows, medical and nursing students in the New Orleans institutions helping to plan and stage the program.

All three courses are acceptable for prescribed hours by AAFP: respiratory care program—29 hours; pulmonary function program—18 hours; and pediatric pulmonary program—16 hours.

For more information write Mr. Raymond at Suite 1504, 333 St. Charles Ave., New Orleans, La. 70130.

Is there a tablet containing *only* an expectorant and *only* Glyceryl Guaiacolate? YES!

1. Patient acceptable tablet dose.
2. Single entity expectorant.
3. Measured tablet dose.
4. Sugar-free tablet.

An identifiable white, scored tablet which significantly stimulates the secretion of respiratory tract fluid.

HYTUSS TABS

(GLYCERYL GUAIACOLATE 100mg.)





Composition: Each sugar-free compressed tablet contains glyceryl guaiacolate 100mg. **Action and Use:** This preparation utilizes the effective expectorant action of glyceryl guaiacolate which significantly stimulates the secretion of respiratory tract fluid. The increased flow of less viscid fluid favors expectoration and has a demulcent effect on the tracheobronchial mucosa. The primary usefulness of Hytuss Tabs is to promote the change from a dry, unproductive cough to a productive cough. Hytuss is therefore useful in treating coughs due to the common cold, bronchitis, laryngitis, tracheitis, pharyngitis, influenza and the measles. The expectorant action of Hytuss may also provide symptomatic relief in some chronic respiratory disorders when the patient experiences spasms of dry nonproductive coughing. **Precautions:** Extremely large amounts may cause nausea and vomiting. **Administration and Dosage:** *Adults*—1 tablet four times daily. *Children*—6 to 12 years of age; ½ tablet 3 or 4 times daily. HOW SUPPLIED: White, scored, sugar-free, tablet in bottles of 100 - 1,000 - 5,000. **Product Identification Mark:** Hy. **Literature Available:** On request.

Available through all drug wholesalers.

Hyrex

HYREX COMPANY
832 South Cooper
Memphis, Tenn. 38104

There's something special about children vomiting

The risk of dehydration . . . plus the psychological stress on both mother and child . . .
greatly increases the urgency in controlling vomiting in children. In addition, there is, of course, need to avoid the extrapyramidal problems associated with phenothiazine medications.



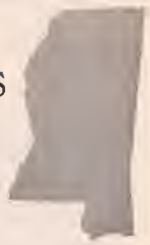
That's why special medication is preferred

WANS® CHILDREN SUPPRETTES™ are specially formulated to stop vomiting and nausea in children—rapidly and with minimal complications.

- WANS are administered rectally—often the best route in the vomiting patient.
- The exclusive WANS formula provides both pyrilamine maleate and sodium pentobarbital for effectiveness . . . contains no phenothiazines or local anesthetics.
- The unique Supprette delivery system rapidly releases effective levels of medication . . . with no oils or fatty acids to affect absorption or cause local irritation.
- WANS SUPPRETTES require no refrigeration . . . no lubrication other than water . . . and dissolve completely, with virtually no leakage.

And for children over 12 years of age and adults suffering from nausea and vomiting, consider higher-strength WANS® No. 1 or WANS® No. 2.

A special favorite* of Mississippi physicians in controlling childhood vomiting



WANS® CHILDREN SUPPRETTES™

rectal antinauseant/antiemetic

pyrilamine maleate 25 mg; sodium pentobarbital 30 mg
Warning: may be habit forming

*Based on usage by dosage form; data gathered by independent research organization.

DESCRIPTION: WANS* Children: (Blue) pyrilamine maleate 25 mg and pentobarbital sodium* ½ gr (30 mg) scored for ½ dosage. WANS* No. 1: (Pink) pyrilamine maleate 50 mg and pentobarbital sodium* ¾ gr (50 mg) scored for ½ dosage. WANS* No. 2: (Yellow) pyrilamine maleate 50 mg and pentobarbital sodium* 1½ gr (100 mg) scored for ½ dosage.

*WARNING: may be habit forming.

CONTRAINDICATIONS: Infants under 6 months. Acute intermittent porphyria, known hypersensitivity to barbiturates or antihistamines, known previous barbiturate addiction, severe hepatic impairment, CNS injury, senility, and presence of uncontrolled pain.

WARNINGS: Barbiturates may be habit forming. Pre-existing psychologic disturbances may be aggravated. Idiosyncratic reactions may occur. Acquired sensitivity may result in allergic reactions. Safety in pregnancy has not been established.

PRECAUTIONS: Use cautiously with other sedative, hypnotic or narcotic agents. Use with caution in patients with acute or chronic hepatic disease, fever, hyperthyroidism, diabetes mellitus, severe anemia, congestive heart failure, or a history of drug dependence or suicidal tendencies. May impair alertness and coordination with increased accident risk.

ADVERSE REACTIONS: Drowsiness, fatigue, vertigo, incoordination, tremor, muscle weakness, ataxia, hypotension, respiratory depression, delirium and coma. Dryness of nose, mouth, and throat, pupillary dilatation or blurred vision, urinary retention, abdominal pain, nausea, vomiting, diarrhea, and hypersensitivity reactions Overdose may result in hallucinations, excitement, ataxia, incoordination, athetosis, convulsions, and death.

DOSAGE AND ADMINISTRATION: Rectally, children 2-12 years of age, one WANS® CHILDREN every 6-8 hours as required. Children under 2 years of age may receive ½ the above dosage. *Adults:* Rectally, one WANS® No.1 Supprette™ to inhibit mild nausea and/or vomiting; one WANS® No. 2 Supprette to control pernicious vomiting Repeat doses for adults should be 4 to 6 hours apart, not to exceed four doses in 24 hours. Moisten finger and Supprette with water before inserting. Optimum dosage must be determined in each case by the clinical response.

WEBCON

Webcon Pharmaceutical Division
Alcon Laboratories, Inc.
Fort Worth, Texas 76101

AN OPEN LETTER TO PHYSICIANS

Many physicians are seeking relief from the ever increasing pressures of medical practice within the private health care sector. The United States Air Force Medical Service is offering an alternative form of medical practice to all physicians who have not reached their 58th birthday. Frankly, we are proud of the quality health care the Air Force Medical Service provides and would briefly take this opportunity to present you a challenge to service.

The Air Force physician practices medicine in a collective endeavor with the entire gamut of medical specialties and the finest trained allied health care professionals. All United States Air Force Hospitals are accredited by the Joint Commission and are equipped with the finest medical instrumentation available. Health care is provided to every patient without regard to the patient's ability to pay. Opportunities for personal development coupled with the professional challenges make ours an ideal environment in which to serve. The Air Force physician has more time for family and personal development in comparison to his civilian counterpart. The liberal fringe benefits made available to the Air Force physician provide for secure, predictable and satisfying lifestyle; e.g., 30 days paid vacation annually, advancement, travel, medical education, professional pay and recreational opportunities.

Your time is very valuable and thus the brevity of this information offering. However, you owe it to yourself to consider this alternative medical practice. Positions are available in primary health care delivery and many medical specialties. Initial appointment can range in the grades Captain through Lt. Colonel with a starting salary range from $30,000 - $40,000 (Bonus included) based on your education, civilian experience and prior U. S. military service. Assignments are arranged at specific Air Force Medical Facilities and are guaranteed prior to your commitment.

For further information, contact:

Captain Lloyd Montero, USAF, MSC
AIR FORCE MEDICAL PLACEMENT OFFICE
DET. 309, 3503 USAFRS
4400 Dauphine St., New Orleans, La. 70146
Or Call Collect 504-589-6914

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
January 1976, Vol. XVII, No. 1

ORIGINAL PAPERS

Surgical Treatment for Vertigo—Sound or Fury?

GALE GARDNER, M.D.
Memphis, Tennessee

CHRONIC VERTIGO secondary to labyrinthine end organ disease is a perplexing problem for patient and physician alike. After etiology in other organ systems has been ruled out, after various methods of medical management have been tried unsuccessfully, and after sufficient time has elapsed to rule out the hope of spontaneous recovery, then the patient is quite likely to ask disturbing questions such as "What *is* causing my dizziness, and can *anything* be done to stop it?" The purpose of this paper is to provide help in answering these questions; but only as they relate to certain types of specific, well established labyrinthine pathology.

Because of the obscure nature of the majority of inner ear disease processes, it is difficult to design an operation to match the pathology. There are, however, two general types of labyrinthine disorders that are understood sufficiently well so as to allow matching surgical procedures to be designed. The first is Meniere's disease, in which the primary pathological feature is an increase in the amount of endolymph within the inner ear. The second is a group of conditions in which damage is produced in only one inner ear as a result of trauma, infection, previous surgery, etc., and which may be thought of clinically as unilateral labyrinthine dysfunction.

Although surgical procedures designed for these specific conditions must have as their primary requirement the relief of vertigo, the patient's hearing must also be considered. Frequently Meniere's disease or the various forms of labyrinthine dysfunction will produce an associated hearing loss of varying degree of severity. For this reason, the ideal surgical procedure should be designed so as to preserve or even improve the patient's hearing.

Meniere's disease and unilateral labyrinthine dysfunction are diagnosed by otologic examination including audiometry, ENG, and temporal bone x-ray. They are usually treated successfully with medical means. When dizziness resulting from these conditions is disabling, surgery may be performed. A variety of surgical procedures is available, depending on the diagnosis and the status of the hearing. The selection and technique of these procedures are described in this paper.

Much of this surgery has been developed quite recently. Because it is new, because it ventures into areas previously considered non-surgical, and because of the tendency for some of these conditions to improve spontaneously without any treatment, surgery for the relief of dizziness is still controversial. Nevertheless, because of the serious nature of the disability resulting from these conditions, it is important that the primary care physician be aware of the surgical treatment now available and able to recognize the indications as well as the contraindications for surgery.

From the Department of Otolaryngology and Maxillofacial Surgery, University of Tennessee, Center for the Health Sciences, Memphis, Tenn.
Presented before the Section on EENT, Mississippi State Medical Association, Biloxi, May 6, 1975.

In taking a history from these patients, it is important to ascertain that the patient's complaint of dizziness is episodic rather than continuous. In this way, cases of peripheral origin may be differentiated from cases of central nervous system origin and from cases of an hysterical nature. Whether the dizziness comes on spontaneously or is induced by positional changes is helpful in differentiating Meniere's disease from other types of pathology.

Whether the complaint is "true" vertigo or some other variety of disequilibrium is a helpful distinction in some patients. When this can be established with certainty, the surgeon feels himself to be on firmer ground in having established the diagnosis of peripheral vertigo. However, much of the time precise identification of the patient's actual sensations comes down to a semantic ordeal between patient and physician. Once the physician recognizes the futility of being always able to ascertain the exact meaning of the patient's words, he is able to relax and not take so seriously the distinction between "vertigo" and "unsteadiness," "off-balance" and even "dizziness." Some patients cannot go beyond these latter terms, even if they are in fact experiencing true vertigo. Nevertheless, the physician must be leery of equating complaints such as "floating," "giddy," "light-headed," and "blackout" with a peripheral etiology.

The presence of symptoms of unilateral hearing loss, tinnitus, and perhaps fullness further establish that the pathologic process is unilateral and peripheral in nature.

Objective evidence of this is obtained by audiometry and ENG. A sensorineural (nerve-type) hearing loss, usually of a low frequency type, is essential in order to make the diagnosis of Meniere's disease. In cases of unilateral labyrinthine dysfunction due to trauma, infection, or prior surgery, usually for otosclerosis, audiometry may or may not show evidence of a hearing loss. The absence of a hearing loss in these situations is an important factor in the selection of the type of surgery to be performed for the relief of vertigo.

ENG utilizes the vestibulo-ocular reflex to measure inner ear balance function, either spontaneously, or induced by head motion or caloric stimulation. One would be very hesitant to perform surgery for Meniere's disease or unilateral labyrinthine dysfunction without definite ENG evidence of unilateral disease on the suspected side, in the form of a reduced vestibular response. In cases of severe head trauma in which total hearing loss and vertigo are present, the surgeon may be reluctant to consider surgery, feeling that the ear is already dead as evidenced by loss of hearing function. ENG, however, may show evidence of residual function, and thereby explain the symptoms and point the way to effective treatment.

The possibility of an acoustic tumor being present as the cause of dizziness makes x-ray examination mandatory in the work-up of these patients. Plain films of the temporal bone are one of the key alerting findings that suggest the possibility of a tumor. Contrast studies with 1-2 cc of Pantopaque injected into the subarachnoid space make the definitive diagnosis.

An FTA should be done to rule out luetic disease. Metabolic studies should be performed to rule out thyroid disease as well as other metabolic disorders. An allergic etiology should also be considered if the history is suggestive.

When other causes of inner ear disease have been excluded and a definite diagnosis of Meniere's disease or unilateral labyrinthine dysfunction has been established, it is important to ascertain whether or not medical treatment has been effective in controlling the symptoms, and if not, whether the severity of the dizziness merits surgical intervention. This usually requires careful observation by the physician over a period of several months or longer. After becoming convinced that the patient needs surgery, I prefer to wait for the patient or the primary physician to raise the question of surgery.

There are three basic procedures that I have found helpful in dealing with chronic vertigo due to the conditions that have been listed. These procedures are (1) the endolymphatic sac shunt operation, which is performed through the mastoid as an otologic procedure; (2) sectioning of the vestibular division of the 8th cranial nerve, which is performed intracranially but extradurally as a combined neuro-otologic procedure; (3) labyrinthectomy with sectioning of the 8th cranial nerve, which is performed through the mastoid and labyrinth as an otologic procedure. The use of the operating microscope, high speed surgical drill, cutting and diamond burrs, and continuous irrigation and suction during the drilling of bone are necessary in performing all of these procedures.

ENDOLYMPHATIC SAC SHUNT

The endolymphatic sac shunt procedure[1] is the operation of choice when the symptoms are definitely the result of Meniere's disease, when dizziness is severe but not controlled medically, and when a sensorineural hearing loss of mild to moderate extent is present. Usually this loss affects predominantly the

lower frequencies, and may show fluctuations. If the hearing loss is less than 30 decibels, the surgeon is usually reluctant to perform surgery. If the loss is greater than 60-70 decibels, and particularly if the speech discrimination score is less than 50 per cent, the shunt procedure is unlikely to be of sufficient help to justify the procedure.

Technique. The procedure is designed to allow drainage of the excess endolymph into the adjacent subarachnoid space. A mastoidectomy is performed. The middle and posterior fossa plates are identified and the posterior bony canal wall thinned but preserved. The mastoid segment of the facial nerve is identified. The incus is not disturbed. The horizontal and posterior semicircular canals are identified and preserved. The bone over the posterior fossa dura is removed, as well as over the sigmoid sinus if depression of this structure facilitates exposure. The endolymphatic duct and sac are located within the dura, usually approximate to the inferior aspect of the posterior semicircular canal, frequently approximate to the inferior aspect of the sigmoid sinus and jugular bulb. An opening is made in the outer wall of the sac and the interior identified with certainty. A small opening is then made in the medial wall of the sac, into the subdural space, the arachnoid identified, and a shunt tube placed through the arachnoid into the subarachnoid space. The central end of the shunt tube remains in the subarachnoid space; the peripheral end, which has an enlarged collar, remains within the endolymphatic sac. Fascia is sutured over the opening in the outer wall of the sac, free temporalis muscle placed within the mastoid space, and the wound closed in layers. A mastoid dressing is applied. Antibiotics are not used postoperatively. The patient usually leaves the hospital after 3-5 postoperative days.

Problems. Cerebrospinal fluid usually drains through the wound for 6-12 hours. The dressing usually remains dry subsequent to this. Rarely a persistent cerebrospinal leak may occur, usually ceasing within three or four days, very rarely requiring secondary closure.

A low grade temperature elevation up to 100° orally usually is present for 2-3 days, then returns to normal. Rarely a higher elevation may occur and may persist for 3-4 days, then usually resolves spontaneously. Occasionally this may persist, necessitating a lumbar puncture. Often in these conditions spinal fluid shows a mild cellular reaction without organisms, probably due to blood in the subarachnoid space. No treatment is necessary for this. Very rarely an organism will be identified, requiring antibiotic treatment for 7-10 days.

More serious problems such as sensorineural hearing loss, facial nerve injury, damage to the sigmoid sinus, damage to the cerebellum or temporal lobe are remote possibilities, and have not occurred in this series. There has been no mortality in this series.

Results. Thirty-two patients with an established diagnosis of Meniere's disease underwent surgery using the endolymphatic sac shunt procedure between Dec. 19, 1969, and July 11, 1973. One patient has been lost to follow-up, leaving 31 patients with current follow-up data.

The mean age of this group of patients at the time of surgery was 41 years. Symptoms had been present for an average of seven years prior to surgery. Seventeen patients were male, 15 female.

Twenty patients (65 per cent) demonstrated improvement as a result of surgery, with control of vertigo and stabilization of hearing. In 11 patients (35 per cent), these objectives were not accomplished.

Regarding the control of vertigo alone, 26 patients (84 per cent) achieved relief from attacks. Regarding hearing results alone, eight patients (26 per cent) showed actual improvement in hearing by speech discrimination score.

VESTIBULAR NERVE SECTION

Sectioning of the vestibular division of the 8th cranial nerve through the middle fossa[2] has the obvious advantage of combining unilateral interruption of an impaired peripheral balance center with preservation of hearings. This is the operation of choice for those cases of unilateral labyrinthine dysfunction other than Menicre's disease in which there is disabling vertigo in the presence of useful hearing. Meniere's disease must be ruled out; otherwise a shunt would be the appropriate procedure. Hearing must be established as useful; otherwise a destructive procedure would be appropriate.

Technique. The procedure is designed to allow sectioning of the vestibular nerve only, without affecting the endolymphatic system directly. I perform this procedure with a neurosurgeon, who makes a vertical incision in the scalp above the involved ear. Soft tissues are retracted and a 1 and ½ inch square block of temporal squamous bone is removed. I then introduce the House-Urban middle fossa retractor, which elevates the temporal lobe. The dura is left intact. In principle, the surgeon is in the same situation as when operating through the mastoid he removes, or finds removed, a large portion of the tegmen, so that in order to operate in the mastoid it is necessary to retract the temporal lobe, covered by intact dura. Next, using either the greater superficial petrosal nerve or the superior semicircular canal,

the geniculate ganglion and facial nerve are identified. The bar of bone immediately posterior to the facial nerve is then identified, which allows recognition of the superior vestibular nerve. Sufficient bone is removed over the internal auditory canal to allow visualization of the contents of the canal after the dura of the canal is incised. The facial nerve and cochlear division of the 8th cranial nerve are preserved, while all branches of the vestibular division are sectioned, with resection of the vestibular division so as to include Scarpa's ganglion. The retractor is removed and the temporal lobe allowed to expand. The bone square is replaced and the wound is closed in layers and a dressing applied. Antibiotics are not used. The patient usually remains in the hospital for 5-7 days postoperatively.

Problems. The problems and complications are similar to those described following endolymphatic sac shunt surgery. In addition, dryness or abnormal tearing of the eye may occur, usually temporarily, because of injury to the greater superficial petrosal nerve. Laceration of the temporal lobe dura and injury to the temporal lobe can occur.

LABYRINTHECTOMY WITH SECTIONING OF THE 8th CRANIAL NERVE

Surgical destruction of the semicircular canals and vestibule, with removal of the neural end organs, along with sectioning of the vestibular and cochlear divisions of the 8th cranial nerve[3] constitutes the most complete approach available when it is desirable to eliminate hearing and balance function in one ear. It is useful in cases of unilateral Meniere's disease or unilateral labyrinthine dysfunction in which the hearing is impaired to the point of no longer being useful to the patient. The cochlear division is sectioned in an effort to reduce or eliminate tinnitus. Other destructive procedures are available, but are less complete in their elimination of labyrinthine function.

Technique. The procedure is designed to eliminate the entire peripheral auditory-vestibular apparatus in such a way as to make regeneration as unlikely as possible. A mastoidectomy is performed as described in the shunt procedure. Next the bone covering the semicircular canals and vestibule is drilled away, exposing the labyrinth. The neural contents are removed. Next the internal auditory canal is identified, the vestibular division differentiated from the facial nerve, and the cochlear division identified. The vestibular and cochlear divisions are sectioned, resecting tissues central to their peripheral ganglions so as to avoid re-growth of the nerve structures and possible recurrence of symptoms. The operation may be performed by sectioning the vestibular division only. The internal auditory canal is covered with free temporalis fascia and muscle, and the wound closed in layers and dressing applied. Antibiotics are not used routinely. The patient remains in the hospital for approximately 5-7 days.

Problems. The complications are the same as described for the endolymphatic sac shunt procedure. In addition, care must be taken to avoid injury to the facial nerve in the internal auditory canal, and to the blood vessels in the adjacent cerebellopontine angle.

CONCLUSIONS

Meniere's disease and unilateral labyrinthine dysfunction are relatively uncommon causes of dizziness. Diagnosis is based on a careful workup, including history, physical examination, audiometry, ENG, and temporal bone x-ray. Other causes of dizziness requiring specific treatment, such as acoustic tumor, lues, and non-labyrinthine disorders must be excluded.

Surgical treatment is rarely necessary for control of vertigo resulting from Meniere's disease and unilateral labyrinthine dysfunction. Spontaneous remission or control with specific, or non-specific, medical treatment usually occur. When dizziness does persist and is disabling, surgery should be considered.

Selection of the surgical procedure to be employed usually depends on the diagnosis and the status of the patient's hearing in the involved ear. Patients with Meniere's disease who retain good hearing are candidates for an endolymphatic sac shunt. Patients with unilateral labyrinthine dysfunction who have good hearing are candidates for a vestibular nerve section through the middle fossa. Patients with either condition who have hearing that is no longer useful are candidates for a translabyrinthine sectioning of the 8th cranial nerve.

If patients with disabling vertigo are to have the maximum amount of benefit, it is important that all physicians, particularly those engaged in primary care, be aware of these surgical procedures and their indications. ★★★

899 Madison—602A (38103)

REFERENCES

1. Gardner, Gale: Endolymphatic Sac Shunt Operation in Meniere's Disease. Transactions of the American Academy of Ophthalmology and Otolaryngology. In press.
2. House, William F.: Middle Cranial Fossa Approach to the Petrous Pyramid. Archives of Otolaryngology 78:460-469, 1963.
3. Pulec, J. L.: Translabyrinthine Section of the 8th Cranial Nerve. Otol. Clin. N. Amer., October, 1968, p. 563.

Cold/Allergy and Cough Country



Rynatan® Country

RYNATAN, for symptomatic relief of colds and allergic rhinitis. Convenient b.i.d. tablet and liquid dosage.

Rynatuss® Country

RYNATUSS, for symptomatic relief of coughs due to colds and in acute and chronic bronchitis. Convenient b.i.d. tablet and liquid dosage.

Mallinckrodt® Pharmaceuticals *Linking chemistry to medicine®*

Mallinckrodt, Inc. St. Louis, Mo. 63147

RYNATAN®: Each tablet contains Phenylephrine Tannate, 25 mg.; Chlorpheniramine Tannate, 8 mg.; Pyrilamine Tannate, 25 mg.

Each 5 ml. (1 teaspoonful) RYNATAN® PEDIATRIC SUSPENSION contains Phenylephrine Tannate, 5 mg., Chlorpheniramine Tannate, 2 mg., Pyrilamine Tannate, 12.5 mg. CONVENIENT B.I.D. DOSAGE for convenience and economy

INDICATIONS: RYNATAN provides symptomatic relief of the coryza and nasal congestion associated with the common cold, other upper respiratory infections and allergic rhinitis. In sinusitis, drainage from the affected sinuses may be improved.

CONTRAINDICATIONS: RYNATAN is contraindicated in those patients who are sensitive to sympathomimetic drugs.

PRECAUTIONS: Use with caution in patients with hypertension, hyperthyroidism, diabetes or coronary artery disease: warn of possible drowsiness in patients who may operate vehicles or machinery.

ADVERSE REACTIONS: Drowsiness and dryness of the mouth are occasionally associated with antihistamine therapy in some individuals.

DOSAGE AND ADMINISTRATION: RYNATAN TABLETS: 1 or 2 tablets every 12 hours.

RYNATAN PEDIATRIC SUSPENSION: For children over six years of age, 5 to 10 ml. (1 to 2 teaspoonfuls) every 12 hours: for children two to six years of age, 2.5 to 5 ml. (½ to 1 teaspoonful) every 12 hours; for children under two years of age, 1.7 ml. (⅓ teaspoonful) every 12 hours.

CAUTION: Federal (U.S.A.) law prohibits dispensing without prescription.

RYNATUSS®: Each tablet contains Carbetapentane Tannate, 60 mg.; Chlorpheniramine Tannate, 5 mg.; Ephedrine Tannate, 10 mg.; Phenylephrine Tannate, 10 mg.

Each 5 ml. (1 teaspoonful) RYNATUSS® PEDIATRIC SUSPENSION contains Carbetapentane Tannate, 30 mg. Chlorpheniramine Tannate, 4 mg. Ephedrine Tannate, 5 mg., Phenylephrine Tannate, 5 mg. CONVENIENT B.I.D. DOSAGE for convenience and economy

INDICATIONS: In the treatment of coughs due to the common cold, asthma, and in acute and chronic bronchitis.

CONTRAINDICATIONS: RYNATUSS is contraindicated in those patients who are sensitive to sympathomimetic drugs.

PRECAUTIONS: Use with caution in patients with hypertension, hyperthyroidism, diabetes or coronary artery disease, warn of possible drowsiness in patients who may operate vehicles or machinery.

ADVERSE REACTIONS: Drowsiness and dryness of the mouth are occasionally associated with antihistamine therapy in some individuals.

DOSAGE AND ADMINISTRATION: RYNATUSS TABLETS: Adults—1 to 2 tablets every 12 hours.

RYNATUSS PEDIATRIC SUSPENSION: For children over six years of age, 5 to 10 ml. (1 to 2 teaspoonfuls) every 12 hours: for children two to six years of age, 2.5 to 5 ml. (½ to 1 teaspoonful) every 12 hours; for children under two years of age, 1.7 ml. (⅓ teaspoonful) every 12 hours.

CAUTION: Federal (U.S.A.) law prohibits dispensing without prescription.

The above represents a brief summary. See package inserts for full prescribing information.

Mississippi State Medical Association



108th Annual Session

May 3-6, 1976

New Holiday Inn Downtown

Jackson

Make your plans now to attend!

Scientific Sections, Specialty Society Meetings, Alumni Social Occasions,
The MSMA Party, House of Delegates, Reference Committees

Problems in Abdominal Surgery
1. Peritoneovenous Shunting for Intractable Ascites

WILLIAM O. BARNETT, M.D.
Jackson, Mississippi

This paper is the first in a series on problems in abdominal surgery to be published every other month by the JOURNAL MSMA. *Prepared by Dr. William O. Barnett, professor of surgery at UMC, the initial article discusses peritoneovenous shunting for intractable ascites and includes management and an illustrative case history.*

ASCITES IS BEST explained according to the principles developed by Starling which hold that the exchange of fluid across capillary membranes is a result of the hydrostatic pressure and osmotic pressure on each side of the membrane. Much information has developed which suggests that ascites forms because of obstruction to the venous outflow routes of the liver. This is the mechanism by which the hydrostatic pressure is increased within the liver with resulting transudation of fluid from the surface and hilus of the liver. Portal venous obstruction is almost never attended by the development of ascites. The Budd-Chiari syndrome which is characterized by obstruction of the hepatic veins is always attended by the development of ascites (see Figure 1). A more common condition which is responsible for ascites is cirrhosis of the liver. Other factors which play a less important but nevertheless significant role are serum albumin, sodium and aldosterone.[4]

The vast majority of cirrhotic patients can be managed quite satisfactorily by nonsurgical measures. These include abstinence from alcohol, salt restriction, diuretics and administration of a nutritionally balanced diet. A small, but significant, minority necessitates more stringent measures. Portacaval shunt has been employed in the management of severe ascites. The end-to-side technique, which has been quite effective in controlling bleeding, has not been attended by a significant measure of success in the management of ascites. Side-to-side shunts have been effective and this is explained by the fact that the liver venous radicles and sinusoids decompress themselves readily by the initiation of reversed vascular flow in the portal veins between the side-to-side portacaval shunt and the liver. The subsequent decrease in venous hepatic hypertension results in cessation of the weeping transudation of fluid from the surface and hilus of the liver. Portacaval shunt is a rather formidable, challenging experience for many of these patients and is attended by a mortality rate which would be expected of these chronically ill debilitated patients. Furthermore, there is little if any evidence that progression of the cirrhotic process in the liver is favorably altered by portacaval shunting. While some cases of intractable ascites may merit the portacaval shunt approach, it is my persuasion that a lesser, effective, palliative procedure may serve a better purpose for most of these unfortunate individuals.

Peritoneovenous shunting represents such an approach (see Figure 2). The principle has been well established over the years by the neurosurgeons in the management of elevated ventricular pressures by a somewhat similar technique. The major challenge for continual function of peritoneovenous shunts has been the occurrence of blood clots in the tubing. This has resulted in the development of a fairly efficient, pressure activated valve which prevents the reflux of blood and eliminates one of the major causes of obstruction.[1, 2, 3, 5] The mechanism operates on the principle of a differential in pressure in the peritoneal cavity and the venous system. As

From the Department of Surgery, University of Mississippi Medical Center, Jackson, Miss.

the pressure increases from advancing ascites, the valve opens, allowing fluid to pass into the venous system from the abdomen. Elevated levels of venous pressure are effective in closing the valve until a

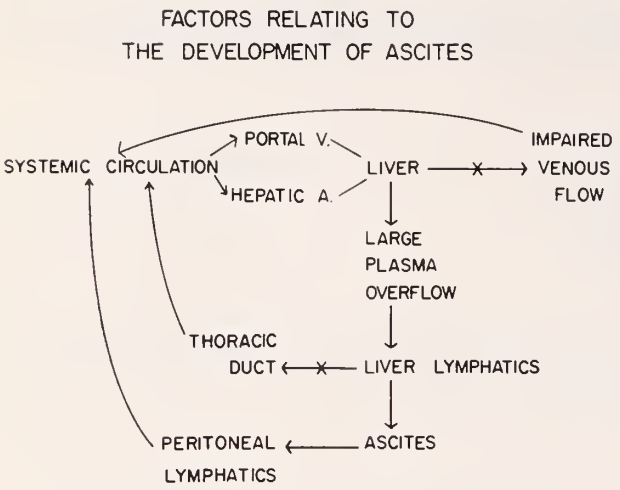


Figure 1. Mechanisms by which ascites may occur.

SHUNT FROM PERITONEAL CAVITY TO INTERNAL JUGULAR VEIN

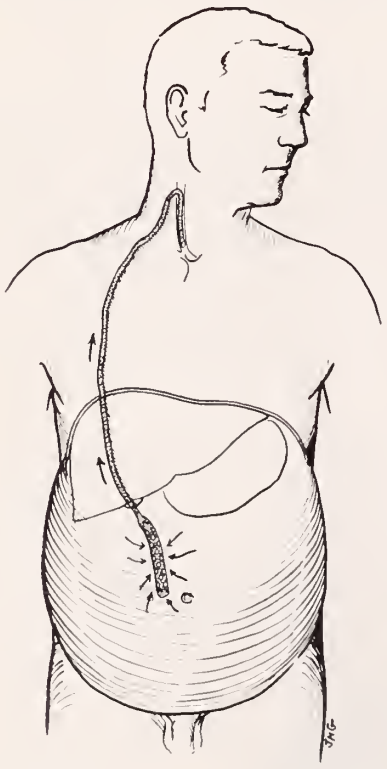


Figure 2. Peritoneovenous shunt for intractable ascites.

significant volume of fluid has passed from the vascular system. Thus, a degree of autoregulation is operational in preventing a too rapid flooding of the venous channels with ascitic fluid.

It is seldom necessary to utilize anesthesia other than the local variety and these chronically ill individuals tolerate the procedure quite well.

ILLUSTRATIVE CASE

H. D., a 66-year-old female, was admitted to the University Hospital with post-hepatic cirrhosis and advanced ascites. The patient was confused and disoriented. Her blood ammonia level was 271 micrograms per cent. Following appropriate medical treatment for hepatic failure, her sensorium improved but the usual therapy for ascites failed to result in improvement. The enormous size of her abdomen made it impossible for her to be ambulatory. Indeed, she could turn in bed only with the greatest of effort. On May 12, 1975, she was carried to surgery where, under local anesthesia, a peritoneovenous shunt was constructed. During the postoperative period she lost 36 pounds. The patient passed 7 liters of urine during the first 48 hours postsurgery. Her abdominal girth decreased by 8 inches. Recent examination showed her to be ambulatory and well pleased with the relief she has obtained.

Our experience thus far involves five cases. In four instances the decrease in abdominal girth has been striking (see Figure 3) and a satisfactory outcome has been achieved. The other case failed to respond as dramatically. This was due, at least in part, to the additional problem of coincidental renal insufficiency with marginal excretion of urine.

Level and duration of improvement relate in a major respect to the dedication and diligence with which postoperative instructions are carried out. These include breathing exercises, wearing an abdominal binder, abstinence from alcohol and dietary precautions.

SUMMARY

Peritoneovenous shunting can be helpful in the palliative management of intractable ascites. In those cases which fail to respond to medical management, the apparatus can be inserted under local anesthesia with little stress to the patient. This is usually followed by progressive relief of ascites, as evidenced by weight loss, decrease in abdominal girth and the passage of large volumes of urine. In four of five cases managed by insertion of this device, very satisfactory results were obtained. ★★★

2500 North State Street (39216)

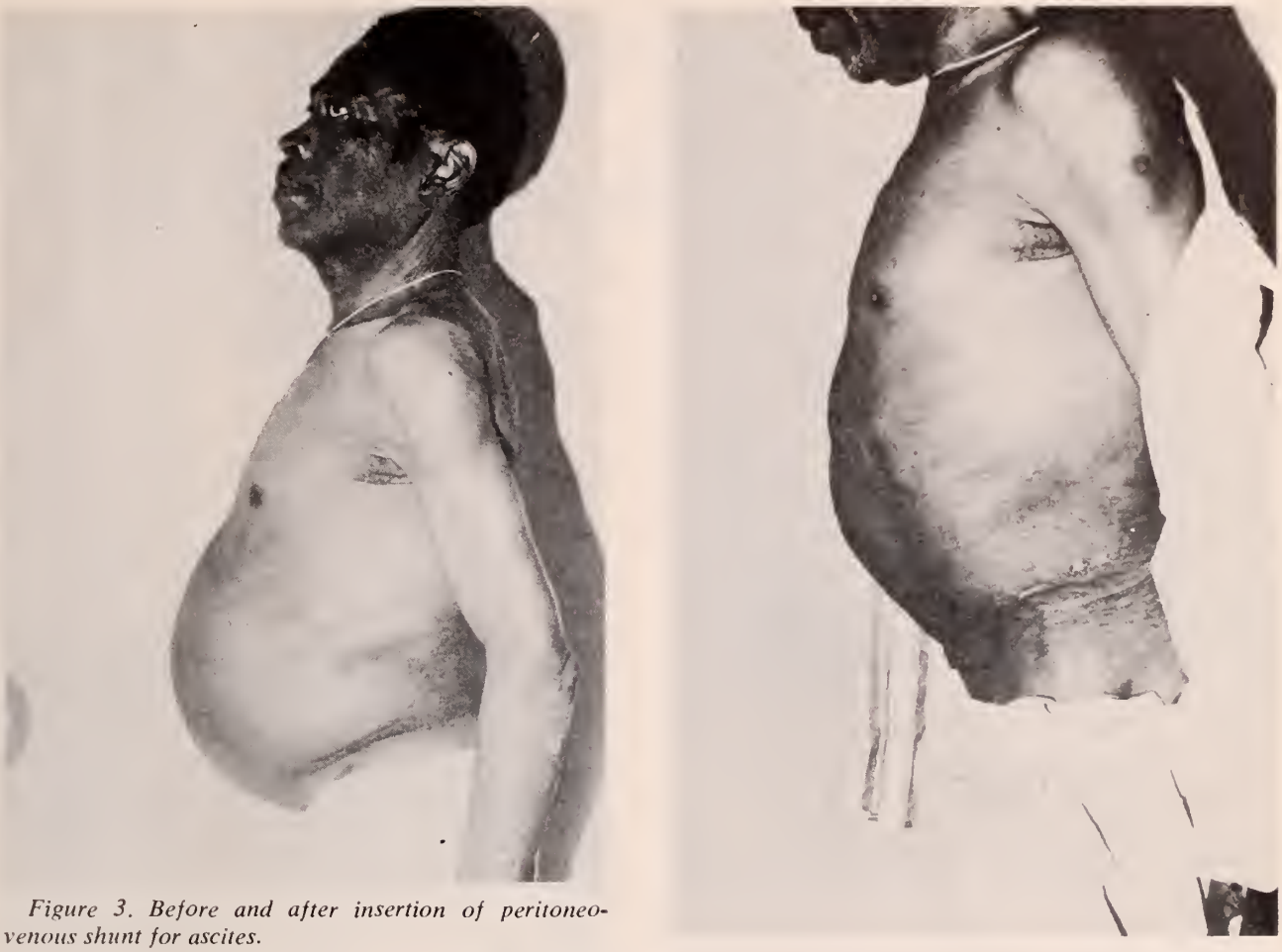


Figure 3. Before and after insertion of peritoneovenous shunt for ascites.

REFERENCES

1. Hyde, G. and Eiseman, B.: Peritoneal a Trial Shunt for Intractable Ascites. Arch. Surg. 95:369, 1967.
2. LeVeen, H. H., Christoudias, G., Ip, M., Luft, R. and Grosbery, S.: Peritoneovenous Shunting for Ascites. Ann. Surg. 180:580, 1974.
3. Mortenson, R. A. and Lawton, R. L.: Surgical Treatment for Intractable Ascites. Am. J. Surg. 116:929, 1968.
4. Sabiston, D. C.: Textbook of Surgery. Philadelphia, W. B. Saunders Company, 1972.
5. Smith, A. N., Preshaw, R. M. and Bisset, W. H.: The Drainage of Resistant Ascites by a Modification of the Spitz-Holler Valve Technique. J. Roy. Col. Surg. Edinb. 7:289, 1962.

Someone will go blind every 12 minutes, says the Mississippi Society for the Prevention of Blindness, adding another 45,000 people to the nation's sightless in the next 12 months. The real tragedy, points out the society, is that current medical knowledge and techniques could save the vision of at least half of these people. What remains is to reach them in time.

Radiologic Seminar CLVIII: Trans T-Tube Extraction of Retained Biliary Stones

JEFF HODGES, M.D.
Pascagoula, Mississippi

RESIDUAL BILIARY duct stones demonstrated after surgery via T-tube cholangiogram present a therapeutic problem. A repeat surgical exploration of the duct for removal can be technically difficult and carries a significant morbidity. The most successful non-surgical removal is via the Dormia-type wire basket[1, 2] utilizing a steerable catheter to facilitate positioning the basket as described by Burhenne.

Introduction and manipulation of the wire basket can be safely and effectively accomplished in the relaxed atmosphere of the fluoroscopy room. Since anesthesia is not required, multiple manipulations may be undertaken. The procedure should be delayed 4 to 5 weeks, with the T-tube remaining to allow a fibrous tract to develop. Large stones may require either crushing or dilatation of the tract, particularly if a small T-tube has been used. A tortuous tract may cause difficulty in catheterization, though simplified by the steerable catheter.

CASE REPORT

M.M., a 61year-old female, had a cholecystectomy on May 26, 1975. T-tube cholangiograms on June 11, 1975 and Aug. 4, 1975 demonstrated a residual stone in the left hepatic duct (see Figure 1a, 1b) not noted on an operative cholangiogram (see Figure 2). The biliary ducts were opacified and the T-tube was removed. A steerable catheter (Medi-Tec) was used to catheterize the tract and the common duct with the tip positioned at the mouth of the left hepatic duct. A sheathed Dormia-type wire basket was advanced through the catheter beyond the stone. The basket was opened with entrapment of the stone. The stone was easily withdrawn through the T-tube tract. The cholangiogram confirms stone removal (see Figure 3). The patient has been asymptomatic without complication.



Figure 1. The postoperative T-tube cholangiogram shows the 7 mm calculus (arrows) clearly in left hepatic duct. (a) June 11, 1975, (b) Aug. 4, 1975, prior to removal of T-tube and stone. *(See next page.)*

Sponsored by Mississippi Radiological Society.
From the Department of Radiology, Singing River Hospital, Pascagoula, Miss.



Figure 1(b)



Figure 2. The operative cholangiogram was called normal. Retrospectively the stone is near the mouth of the left hepatic duct.

COMMENT

The Dormia-type wire basket removal of retained biliary tract stones is safe and effective. The introduction of the basket is simplified by use of a steerable catheter under fluoroscopic visualization with opacification of the biliary ducts and identification of the stone.

Retained biliary duct stones will continue to occur in spite of careful palpation and operative cholangiograms. Compared to re-operation or attempts at stone dissolution, this method offers a safe and effective treatment of retained biliary stones. ★★★

1365 Market Street (39567)

REFERENCES

1. Burhenne, H. J.: Non-Operative Retained Biliary Tract Stone Extraction. A New Roentgenologic Technique. Am. J. Roent. 117:388-399, Feb. 1973.
2. Bean, W. J., Smith, S. L. and Colonje, M. A.: T-Tube Tract Dilatation for Removal of Large Biliary Stones. Radiology 115:485-486, May 1975.



Figure 3. Post extraction cholangiogram confirms removal of stone.

A History of Medical Publications in Mississippi

NOLA GIBSON
Jackson, Mississippi

THE MISSISSIPPI STATE Medical Association (MSMA) was founded in Jackson on Dec. 15, 1856.[1] The association adjourned to meet on the second Monday in November of 1857, but there was no other meeting (presumably because of the War Between the States) until April 1869, when in pursuance of a call made by the Vicksburg Medical Society, Mississippi physicians assembled in Jackson to reorganize. Officers and delegates to the American Medical Association were elected and the constitution and by-laws of the first meeting were readopted with a few minor changes.[1] Thereafter, the association met on a more or less regular basis. Early proceedings were recorded only vaguely, "in the memory of a few of the older members."[1]

THE TRANSACTIONS

The first mention of any kind of publication was found in 1874 when *The History of the Mississippi State Medical Association* reported, "Finances were in such bad shape that a committee was appointed to ask an appropriation of $300 per annum from the legislature to defray cost of publishing the Transactions."[1] The Transactions or proceedings of the association's annual meetings have continued to be published, in separate bound form and in the various publications sponsored by the MSMA. The August issue of the JOURNAL MSMA now contains the full text of each year's proceedings.

MISSISSIPPI MEDICAL RECORD

One of the features of business at the 1897 annual meeting was the establishment of a monthly journal to be published in lieu of the Transactions, by taking over the *Mississippi Medical Record* which had just been established as a private venture in Vicksburg by Dr. E. F. Howard. The journal was continued for four years after which the MSMA discontinued support and returned to the former method of issuing annually a bound volume of Transactions.[2]

At the 1904 annual meeting, the association reported its largest membership to date, 520 physicians, and decided to resume relations with a monthly publication. MSMA adopted as its official organ the *Journal of the Mississippi State Medical Association,* published in Vicksburg. The name was changed in 1906 to the *Mississippi Medical Monthly.*[2]

The *Mississippi Medical Monthly* was published for 17 years, but the journal changed names and sponsorship several times (as indicated above) within those years, 1897-1914. According to the State Board of Health's Library index notes, in July 1914 the *Mississippi Medical Monthly* merged into the *Pan American Surgical and Medical Journal.*[3] The author was unable to find any information on this publication.

NEW ORLEANS MEDICAL AND SURGICAL JOURNAL

In 1923 the Louisiana State Medical Society purchased the *New Orleans Medical and Surgical Journal* and in 1924 invited the Mississippi State Medical Association to abandon the Transactions and adopt that journal as its official organ. MSMA accepted the invitation and by 1931 the editorial board had succeeded in building up a greatly increased interest in the Mississippi section of the official journal, *NOMSJ.*[2] "An effort was made to get as good material to publish as possible without publishing poorly prepared material. All 82 counties had an editor and each editor was graded on his activities by the number of articles sent in for publication," as recorded in the MSMA history, volume two. Due to a loss of advertising payment in 1933, the journal began losing money.[2] There was no record of MSMA sponsorship after that year.

THE MISSISSIPPI DOCTOR

The Mississippi Doctor was established as a house organ by Houston Hospital in June 1922 "for disseminating ideas of Mississippi medical men and

Managing Editor, JOURNAL MSMA.

thereby be helpful to the profession and ultimately the people we are all trying to serve."[4] The idea of a monthly medical journal to bring the latest and best in medicine to the doctors of this area (i.e. North Mississippi) was conceived by Dr. V. B. Philpot of Houston.[4] The first issue was published in July 24, 1922, but was marked Volume 1, Number 2.

In December 1924 the journal was adopted by the 11 Counties Medical Society and continued to be published in Houston until March 1925 when Dr. W. H. Anderson of Booneville was named manager and editor-in-chief. "It was agreed that we would have full charge and that the 11 Counties Medical Society would be exempt from all financial responsibility," according to Dr. Anderson.[4] From that date the journal was published monthly in Booneville, Mississippi, and the subscription price was $1.00 per year.[4] Mrs. Anderson served as assistant editor and the journal was printed at the Andersons' printing shop. Dr. Anderson also edited and published the *Booneville Independent,* a weekly newspaper.

The journal was adopted as the official organ by the Mid-South Postgraduate Medical Assembly in 1935 and by the Mississippi State Medical Association on Jan. 1, 1936.[4]

In 1933 *The Mississippi Doctor's* masthead stated that it was the official organ of the Northeast Mississippi 13-County Medical Society, North Mississippi Medical Society and Mid-South Postgraduate Medical Assembly.[5]

On the masthead in 1943 was "official organ of the Mississippi State Medical Association and the Mid-South Postgraduate Medical Assembly" plus "The Journal with a vision which encourages a plan of delivering modern medicine to the masses at less cost to the individual and more profit to the practitioner. It champions the community hospital, the hub around which this service must be built."[6]

Dr. Anderson gave the philosophy behind the publication in an address before the North Mississippi Historical Society. "We supported *The Mississippi Doctor* in every way we could from its founding. There was a noble purpose behind it, and we could see the urgent need for such a publication, which could render an invaluable service to rural medicine and the small hospitals throughout the Mid-South. . . . Its contents were not always confined to scientific medicine. Attention sometimes turned to lay problems. Its vision from the beginning was to build a citizenship physically, mentally and spiritually adequate to meet the problems of modern society. The journal shrank from commercialism. One evidence of this was that advertising could never crowd out an inspirational gem or special thought on the front cover."[4]

He continued, "When the journal became the organ for the Mid-South Postgraduate Medical Assembly, in a manner it exchanged its philosophy for the best of the nation's medical talent. . . . *The Mississippi Doctor* sought original contributions from men in general practice, as well as the specialties. It often published the papers of young men who were candidates for membership in the College of Surgeons or the College of Medicine, or who had developed a noteworthy technique, or who could present an unusual case report. . . ."[4]

Other comments included: *"The Mississippi Doctor* may be considered a good example of private enterprise. From its beginning it charged one dollar a year for a subscription, and years later its contract price to the state association was no more than this. For a high-class ethical medical journal, this must be exceptional."[4]

The journal also reported society news and exhibited leadership in advocating the community hospital, seeking legislation asking for 15¢ per capita for the indigent poor per county to cover hospital costs, and in getting the Legislature to establish the four-year medical school. The publication had a "newsy" flair with many personal items about physicians and their families. In 1933 the journal published an address by Dr. G. S. Bryan to the Woman's Auxiliary in which he said, "The acquirement and dissemination of medical knowledge and service to mankind are fundamental principles underlying the urge to organize of medical associations, yet the social instinct is a dominant factor."[4] In an editorial published in the November 1943 issue, Dr. Anderson wrote, "Medical journals and medical associations keep medical information in liquid form and keep it flowing in applied service."[6]

The last issue of *The Mississippi Doctor* was published in December 1959; it was the 37th volume. The journal had served as the official organ of MSMA for 24 years and of the Mid-South Assembly for 25 years. Subscription price was then $3.00 per year. The editor and publisher of *The Mississippi Doctor* agreed to transfer ownership of the journal to the Mississippi State Medical Association on Jan. 1, 1960.[7] The transfer was due to several influences, according to Dr. Anderson:[7]

1. *The Mississippi Doctor* was the last surviving state medical journal that was privately owned.

2. The forces of centralization had attained overpowering strength. *"The Mississippi Doctor,* in effect, was the last citadel of independent thought and operation within the state organization," he wrote.

3. A state journal advertising bureau was established by the AMA primarily to help subsidize struggling state medical journals. "The advertising field has grown into a spectacularly lucrative business," he said.

4. In addition to being an additional source of income to the state association, the journal could also be enlarged.

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

In 1960 the first volume of the *Journal of the Mississippi State Medical Association (Journal MSMA)* was published by the MSMA. The new journal replaced *The Mississippi Doctor* and was a totally new and different publication. The MSMA Board of Trustees had decreed that the *Journal MSMA* be conceived and implemented to provide:

> a scientific and socioeconomic vehicle especially adapted to the needs of the MSMA and a reliable, authoritative communication medium among the membership, attractive in format, easily and highly readable, and containing a sufficient variety of presentations and information to achieve wide usefulness.[8]

The Board further stated that the *Journal MSMA* should not be utilized for purposes other than those serving the association's interests or as a means to create policy or suggest deviation from established policy. Editorially, the Board continued, the journal should, at all times, reflect accurately and consistently policies of the association as regards goals, programs and views of Mississippi medicine.[8]

Rowland B. Kennedy, MSMA Executive Secretary, served as managing editor and Betty Sadler was named editorial assistant. The Board named a Committee on Publications to oversee publication of the journal and the association's Constitution and By-Laws were amended to provide for an editor and two associate editors to be elected from the membership for two-year terms. The new journal was to be printed by The Ovid Bell Press, Inc., of Fulton, Missouri, an established printer of scientific journals and books. The journal's format consisted of original scientific articles and case reports, medical organization news, editorials and regular monthly departments including deaths, new members listing, president's page and personals.

At the end of the first year of publication, Dr. Lawrence W. Long, chairman of the Committee on Publications, wrote: "The total aim is to fulfill the assigned mission of providing a scientific and socioeconomic vehicle especially adapted to the needs of the association, a reliable and authoritative communication medium among the membership, containing a sufficient variety of presentations and information to achieve wide usefulness."[9]

Dr. Long continues to serve as chairman of the Committee on Publications and physicians who have served on the committee of which the editors are part include: W. H. Anderson (first editor); Thomas J. Marland (second editor); W. Moncure Dabney (third and current editor); Dewitt W. Hamrick; Louis F. Rittelmeyer; B. B. O'Mara; J. Harvey Johnston, Jr.; William E. Lotterhos; George H. Martin; Thomas W. Wesson; Frank L. Butler, Jr.; T. A. Baines; and Myron W. Lockey.

The present managing editor of the *Journal MSMA* joined the staff in 1969. The emphasis of the publication remains solidly around Mississippi medicine. The magazine retains its basic format but has shrunk in size (number of pages per issue) due to decreased pharmaceutical advertising. The tendency is to publish more socioeconomic articles, since the journal cannot compete with highly specialized and technical scientific journals, and more MSMA activities and policy content. Other departments added include the postgraduate calendar and medico-legal briefs. Three newsletter-type pages are now included in each issue to give a brief summary of events of interest to MSMA members.

A readership survey is currently being conducted. When the results are in and analyzed, the Committee on Publications will take them into account to ensure that the publication continues to meet the needs of the membership. ★★★

P.O. Box 5229 (39216)

REFERENCES

1. Hall, J. C.; Sutherland, H. L.; and Howard, E. F.: *History of the Mississippi State Medical Association,* 1910. pp. 9-25.
2. Thompson, James Grant: *History of the Mississippi State Medical Association,* 1949. Second Edition. pp. 14-24.
3. Indexed Notes, Mississippi State Board of Health Library.
4. Anderson, W. H.: "Brief History of *The Mississippi Doctor." Northeast Mississippi Historical Journal,* vol. I, No. 1, pp. 12-14, 20 (1966).
5. Anderson, W. H.: *The Mississippi Doctor.* (July 1933) pp.1, 3-9, 23-24.
6. Anderson, W. H.: *The Mississippi Doctor.* (November 1943) pp. 1, 169.
7. Anderson, W. H.: *The Mississippi Doctor.* (November 1959) pp. 156-157.
8. First annual report of the *Journal MSMA.* Transactions of the Mississippi State Medical Association. May 10-12, 1960.
9. Long, Lawrence W.: "Volume II, Number 1." *Journal of the Mississippi State Medical Association.* January 1961) pp. 21-27.



Big Balanced Rock, Chiricahua Mountains, Arizona (approx 1,000 tons)

□ Found useful in the management of vertigo* associated with diseases affecting the vestibular system.
□ Can relieve nausea and vomiting often associated with vertigo.*
□ Usual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.
□ Also available as Antivert (meclizine HCl) 12.5 mg. scored tablets, for dosage convenience and flexibility.
□ Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for nausea, vomiting and dizziness associated with motion sickness.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*



Documented bioavailability...
Regimen flexibility

q.i.d. or q 6h immediately after or between meals

E-Mycin®

erythromycin enteric-coated tablets, Upjohn

250 mg

Formulated for quality...
Priced for economy.

Upjohn

See facing page for brief summary of prescribing information.

J-4889-9

E-MYCIN® TABLETS — 250 mg — For Oral Administration (erythromycin enteric-coated tablets, Upjohn)

E-Mycin Tablets (erythromycin enteric-coated tablets) are specially coated to protect the contents from the inactivating effects of gastric acidity and to permit efficient absorption when administered either immediately after meals or when given between meals on an empty stomach.

Indications: *Streptococcus pyogenes (group A beta-hemolytic streptococci):* Upper and lower respiratory-tract, skin, and soft-tissue infections of mild to moderate severity. Parenteral benzathine penicillin G is considered by the American Heart Association to be the drug of choice in the treatment and prevention of streptococcal pharyngitis and in long-term prophylaxis of rheumatic fever. When oral medication is necessary (because the parenteral route is contraindicated) or if there is known allergy to penicillin, the following recommendations made by the American Heart Association apply: 1) Oral penicillin G or V (where no allergy exists)—This is the drug of choice. Give for a minimum of 10 days; 2) Erythromycin—Give for a minimum of 10 days. A few strains of streptococci resistant to erythromycin have been reported.

Alpha-hemolytic streptococci (viridans group): Short-term prophylaxis against bacterial endocarditis prior to dental or other operative procedures in patients with a history of rheumatic fever or congenital heart disease who are hypersensitive to penicillin. (Erythromycin is not suitable prior to genitourinary surgery where the organisms likely to lead to bacteremia are gram-negative bacilli or the enterococcus group of streptococci.)

Staphylococcus aureus: Acute infections of skin and soft tissue of mild to moderate severity. Resistance may develop during treatment.

Diplococcus pneumoniae: Upper respiratory-tract infections (e.g., otitis media, pharyngitis) and lower respiratory-tract infections (e.g., pneumonia) of mild to moderate degree.

Mycoplasma pneumoniae (Eaton agent, PPLO): In the treatment of primary atypical pneumonia, when due to this organism.

Treponema pallidum: Infections due to this organism.

Corynebacterium diphtheriae and *Corynebacterium minutissimum:* As an adjunct to antitoxin, to prevent establishment of carriers, and to eradicate the organism in carriers. In the treatment of erythrasma.

Entamoeba histolytica: In the treatment of intestinal amebiasis only. Extra-enteric amebiasis requires treatment with other agents.

Listeria monocytogenes: Infections due to this organism.

Contraindication: Contraindicated in patients with known hypersensitivity to erythromycin.

Warning: Safety for use in pregnancy has not been established.

Precautions: Erythromycin is principally excreted by the liver. Caution should be exercised in administering the antibiotic to patients with impaired hepatic function. Surgical procedures should be performed when indicated.

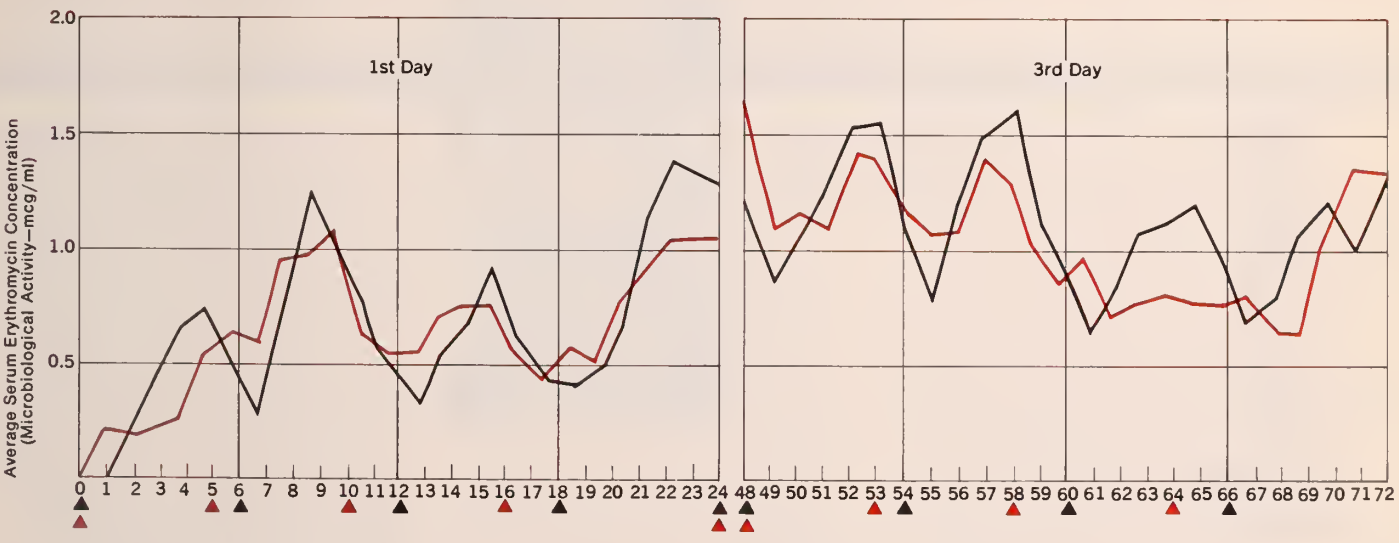
Adverse reactions: The most frequent side effects of erythromycin preparations are gastrointestinal, such as abdominal cramping and discomfort, and are dose-related. Nausea, vomiting, and diarrhea occur infrequently with usual oral doses. During prolonged or repeated therapy, there is a possibility of overgrowth of non-susceptible bacteria or fungi. If such infections occur, the drug should be discontinued and appropriate therapy instituted. Mild allergic reactions such as urticaria and other skin rashes have occurred. Serious allergic reactions, including anaphylaxis, have been reported.

Treatment of overdosage: The drug is virtually nontoxic, though some individuals may exhibit gastric intolerance to even therapeutic amounts. Allergic reactions associated with acute overdosage should be handled in the usual manner—that is, by the administration of adrenalin, corticosteroids, and antihistamines as indicated and the prompt elimination of unabsorbed drug, in addition to all needed supportive measures.

How supplied: 250 mg—in bottles of 100 and in unit-dose packages of 100 enteric-coated tablets. Caution: Federal law prohibits dispensing without prescription.

For additional product information, consult the package insert or see your Upjohn Representative.

Demonstrated bioequivalence of E-Mycin taken immediately after meals or between meals.



Regimen A (after meals)—One 250 mg E-Mycin® tablet administered q.i.d. immediately after breakfast, lunch, and dinner, and at bedtime with a snack.

Regimen B (between meals)—One 250 mg E-Mycin tablet administered q 6h at least two hours after meals.

E-Mycin Study CS076 on file at The Upjohn Company. The study was performed with twenty-two normal male adult volunteers utilizing a randomized two-way complete crossover design.

No statistically significant difference in area under the curve was observed from 0-24 hours or 48-72 hours at the 95% confidence level ($p > .05$).

The data clearly demonstrate that E-Mycin, when administered q.i.d. immediately after meals, produced average serum levels equivalent to those obtained when the drug was administered q 6h at least two hours after meals.

E-Mycin®

erythromycin enteric-coated tablets, Upjohn

250 mg

Formulated for quality... priced for economy

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001, U.S.A.
© 1975 The Upjohn Company
MED 8-7 S

Opinion & Dialogue

Should a specially prepared package insert be made available to patients?



Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration



Dr. James H. Sammons
Executive Vice President
of the American
Medical Association

The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A



The President Speaking

"Thoughts on the Health Care Scene"

JACK A. ATKINSON, M.D.
Brookhaven, Mississippi

A FEW WEEKS AGO I was invited by the sophomore class of the University of Mississippi Medical School to participate in a panel discussion on the subject of national health insurance and other health related bills which are before Congress at the present time. As we discussed the socioeconomics of medicine with these highly intelligent and alert young people, I was reminded of the words of Sir William Osler: "From two points of view alone we have a wide and satisfactory view of life. One, as, amid the glorious tints of the early morn, ere the dew of youth has brushed away, we stand at the foot of the hill, eager for the journey. The other, wider, perhaps less satisfactory, as we gaze from the summit, at the lengthening shadows cast by the setting sun. From no point in the ascent have we the same broad outlook, for the steep and broken pathway affords few places with an unobscured view."

From the vantage point of well over a quarter of a century involvement in the practice of medicine, I have witnessed a continuous evolution toward a better quality of health care in this country. And today I must agree with Dr. Russell Roth that more people are receiving better medical care by better trained doctors than ever before in the history of our nation. It is difficult for me to understand, therefore, why so many of our congressional leaders insist that abandonment of our present health care system is so necessary and why they think the system must be restructured and reorganized.

We in Mississippi are attempting to implement the Health Planning and Resourses Development Act of 1975. A health systems agency will be designated for our state at some time in the future, and I think it is important that adequate representation by practicing physicians be on the governing board of this agency. This law calls for reorganization of the health planning agencies in our state. The system will replace the Regional Medical Program, the Comprehensive Health Planning Program, the Hill Burton Program, and hopefully something good will come from the implementation of Public Law 93-641. I cannot help but be concerned, however, about the constant process of reorganization on the national level, and I am reminded of a statement I read recently: "We trained hard but it seemed that everytime we were beginning to form into teams we would be reorganized. I was to learn later in life that we tend to meet any new situation by reorganizing. And a wonderful method it can be for creating the illusion of progress while producing confusion, inefficiency, and demoralization."

This comes from a speech by Petronieus Arbiter delivered in Rome nearly 2,000 years ago. ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XVII, NUMBER 1
JANUARY 1976

EDITORIALS

The Past, Present, and Future of Emergency Medical Care in the State of Mississippi

The organization, centralization, utilization and improvement of emergency medical care in the state of Mississippi has been going on for many years. Initially, the American College of Surgeons Trauma Committee assumed the role of developing emergency medical care within the state. It was the College of Surgeons Trauma Committee, along with other concerned individuals, who laid the groundwork for the first National Conference on Emergency Medical Services. This meeting culminated the initial work that had been done by the National Academy of Sciences and National Research Council on "Accidental Death and Disability—the Neglected Disease of Modern Society," the proceedings of which were published in September 1966. For the first time the public and governmental officials realized that accidental disease had too long been neglected and thus began investigating the number one killer of the young person in the United States. This committee developed various curricula for the training of emergency medical technicians, set up standards for ambulance services, and established a national registry for emergency medical technicians. The committee also developed designs for emergency medical vehicles, as well as standards for equipment to be used on these vehicles.

The second National Health Conference, which was held in December 1971, prompted President Nixon in his State of the Union Address to demand improved emergency medical care. Shortly thereafter, a bill was introduced into Congress which created the first Emergency Medical Services Act. However, the initial bill was vetoed by the president because of a rider dealing with the operation of Public Health Service hospitals. For once, organized medicine endorsed and encouraged a form of federal medicine, and in November 1973, the Emergency Medical Services Act was reintroduced in Congress. It passed unanimously and, following presidential signature, became Public Law No. 93-154. The law provided assistance for and encouraged the development of comprehensive area-wide emergency medical units. The law further provided for the awarding of grants and contracts for feasibility and planning studies, the establishment of operational systems of emergency medical services, the expansion of systems already in existence, and for the research and development of emergency medical devices. The law also required participation by the consumer as the operational policies were formulated. Continued training in emergency medical services techniques for all involved in health care was declared mandatory. It also required education of the public in emergency medical care techniques. Since the law itself gave a great deal of weight to the education of not only the public, but the provider as well, this had a profound effect upon health educational institutions. It permitted programs to be funded and required people who practice emergency medical care to be knowledgeable in their specialty.

In certain areas, the state of Mississippi had begun to develop emergency medical care systems, and shortly after the President's State of the Union Address, a comprehensive committee was appointed by Governor Waller to deal with the basic planning and establishment of emergency medical services throughout the state. The committee was composed of doctors, nurses, administrators, legislators, and lay personnel who were interested in the development of an area-wide emergency medical service within the state.

This organization was well into the planning phase when legislative acts came into being. This committee not only formulated statewide planning but also categorized all of the emergency medical facilities within the state, a task which was completed in December of 1973. Subsequently, the state legislature in its 1974 session enacted laws establishing an Emergency Medical Services Advisory Council which was to have the sole responsibility of carrying out and implementing the act that had been passed. The legislation dealt with the training of emergency medical technicians, the specifications of ambulances, and the equipment that was to be available on all ambulances within the state of Mississippi.

In order to facilitate implementation of this law, the state of Mississippi has been divided into four basic emergency medical services regions, with 10 districts within each region. There is a statewide emergency medical services director, as well as a medical control director. Each of the four regions has a medical director and a health planner. These physicians and health planners are attempting to look at the state, both on a regional and central level, and develop plans, not only regarding ambulance services and emergency medical technicians, but hospital care in critical areas as well.

The Department of Health, Education, and Welfare, through its funding system in continuing education, is encouraging each state and each area within the state to develop critical care plans from various critical care areas. These include coronary care, burn care, trauma care, poison care, psychiatric and drug overdose care, and neonatal care. They are encouraging not only specialized centers but asking that smaller areas without specialized centers fit into the overall plan within the state with regard to initial care and transportation of the emergency victim.

It is, therefore, imperative that each of us as physicians develop within our hospitals and emergency care area a comprehensive plan that will utilize the talents that we have within our area. In certain areas, facilities will be limited and we will have to refer patients to larger areas. In other areas, referrals will have to cross state lines to go to specialized centers. However, all of these can be implemented into an area-wide and a statewide plan.

It is hoped that every physician within the state will show an interest in emergency medical care, thus involving himself in the development and teaching of emergency medical care, in addition to providing these services to the people of our state. In the next few months, as we begin to organize the entire state of Mississippi into one emergency medical services area, many physicians will be contacted and asked to give of their time, as well as knowledge gained while serving within their communities.

W. Briggs Hopson, Jr., M.D.
State EMS Medical Control Director
The Street Clinic
Vicksburg, Miss.

The Bicentennial

With the publication of the article on the history of Mississippi medical publications in this issue, the Journal MSMA would like to commemorate the celebration of the Bicentennial. The association has always placed importance on history as evidenced by the publication of MSMA histories in 1910 and in 1949. During 1976, the Board of Trustees has decreed that another history of the association be published; the new history will go back to the beginning of the MSMA and continue through the activities of the current year. Chairing this substantial undertaking is Dr. John Y. Gibson of Jackson, a radiologist whose interest in medical history is well known to Mississippi physicians. He was also instrumental in reorganizing the History of Medicine Society which meets quarterly at the University Medical Center. The Journal hopes to publish articles taken from programs given before the society during this Bicentennial year. Comments and any information about Mississippi medical history will be welcomed by Dr. Gibson and the Journal staff.—NG

Medicare Changes Are Approved

Congress has approved an amendment to the Medicare law which will forestall rollbacks in some physicians' Medicare reimbursement.

An unintended effect of the HEW Department's new Medicare reimbursement index tying physicians' Medicare fees to a cost-of-living-type formula was to cause some reimbursement levels to be less this year than last despite rises in the cost of living. The amendment will prevent any reimbursement to be less this fiscal year than allowed previously.

POSTGRADUATE CALENDAR

Jan. 26-30, 1976

NEPHROLOGY INTENSIVE COURSE
University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center, Division of Continuing Health Professional Education with partial support from Mississippi Regional Medical Program

Coordinator:
John D. Bower, associate professor of medicine and director of the artificial kidney unit, the University of Mississippi School of Medicine

This clinically oriented one-week course will emphasize the reversible and treatable forms of kidney disease, particularly the reversible features of chronic kidney disease. Participants will cover the management of pyelonephritis, glomerulonephritis, nephrotic syndrome, fluid and electrolyte problems, and acid base balance. They will become familiar with physiology, pathology, radiology, immunology, urology, transplantation, and hemodialysis in clinical nephrology.

Jan. 30-31

MISSISSIPPI-LOUISIANA REGIONAL MEETING OF THE AMERICAN COLLEGE OF PHYSICIANS
University Medical Center, Jackson

Sponsored by the Mississippi-Louisiana American College of Physicians, Mississippi-Louisiana Societies of Internal Medicine, and the University of Mississippi Medical Center Division of Continuing Health Professional Education

Coordinator:
Guy D. Campbell, M.D., professor of medicine, the University of Mississippi School of Medicine

Topics include certification and recertification in internal medicine, fiberoptic bronchoscopy, environmental factors in respiratory disease, echocardiography, and new techniques in diagnosing allergies. Principal speaker Dr. James A. Clifton, chairman of the Department of Internal Medicine at the University of Iowa Hospitals and Clinics, will discuss "genes, guts, and kidneys."

Feb. 23-25, 1976

UROLOGY INTENSIVE COURSE
University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center, Division of Continuing Health Professional Education with partial support from Mississippi Regional Medical Program

Coordinator
W. Lamar Weems, M.D., professor of surgery (urology) and chief of the division of urology, the University of Mississippi School of Medicine

This course is structured to give the primary physician an overview of current methods of diagnosing and treating common urological diseases. Topics to be covered include urinary tract infections, benign prostatic hyperplasia, cancer of the prostate, kidney and testicles, stones, septicemia, urethral strictures, trauma, infertility and impotence, catheter care, and the neurogenic bladder.

FUTURE CALENDAR

Mar. 3-5, 1976
ENT INTENSIVE COURSE

Mar. 11-13
SURGICAL FORUM III

Mar. 18-20
NEUROLOGY/NEUROSURGERY INTENSIVE COURSE

Mar. 24-27
AMERICAN COLLEGE OF PHYSICIANS HEMATOLOGY/ONCOLOGY CONFERENCE

April 5-9
PULMONARY MEDICINE INTENSIVE COURSE

April 19-23
NEPHROLOGY INTENSIVE COURSE

April 27-28
EMERGENCY CARE COURSE

The University of Mississippi Medical Center Division of Continuing Health Professional Education offers intensive refresher courses to meet physicians' clinical practice needs in the specialties most requested. Mississippi Regional Medical Program partially supports the series open to all physicians. Intensive courses are eligible for AMA Physician Recognition Award Category I credit. Enrollment is limited, and applications are accepted in the order received. All correspondence about intensive and other courses should be addressed to Continuing Health Professional Education, University Medical Center, 2500 North State Street, Jackson, MS 39216.

PERSONALS

O. J. Andy of Jackson and UMC presented a paper on "limbic system seizures and aggression" at the Pavlovian Society meeting in Los Angeles.

James F. Arens of Jackson and UMC was visiting professor to the UCLA Medical Center Nov. 17-19.

M. L. Arrington announces the opening of his medical practice at The Medical Center in Prentiss.

Jack A. Atkinson of Brookhaven, MSMA president, was a guest at the November meeting of the West Mississippi Medical Society in Vicksburg.

Helen B. Barnes of Jackson and UMC has been named to the Comprehensive Sickle Cell Center Review Committee which met during November in Chevy Chase, Md.

Eugene V. Bramlett, health officer for Panola, Quitman and Lafayette counties, retired on Jan. 1.

Harry E. Burrow of Pascagoula is the new president of the Singing River Medical Society and Dewey Lane of Pascagoula is secretary-treasurer.

Charles Caccamise of Jackson went to the Association of Professors of Dermatology meeting in November in Washington, D. C.

Marion E. Cockrell announces the relocation of his practice of obstetrics and gynecology to Hospital Plaza, Vancleave Road in Ocean Springs.

J. F. Eckford of Starkville was honored as an outstanding alumni of Starkville public schools during ceremonies for American Education Week.

John Ederington of Vicksburg is new president of West Mississippi Medical Society. Other officers are: Briggs Hopson, Jr., vice president; Karl Hatten and Tom H. Mitchell, convention delegates; M. E. Hinman, secretary-treasurer; Joe Ross, alternate delegate; Charles Marascalco, Frank McPherson and John Evans, Board of Censors.

C. E. Fox, III, has assumed new duties as district III health officer.

James D. Hardy of Jackson and UMC was Third Sylvan Oestreicher visiting professor and guest speaker on "cardiovascular injuries and their management" at St. Clare's Hospital and Health Center in New York.

Dewey H. Lane of Pascagoula is serving as vice president of the Mississippi Economic Council and will become MEC president on May 1, 1976.

Helen McGehee announces the opening of her office for the practice of family medicine on Hwy 90 East in Biloxi.

David Owen of Hattiesburg is serving as president of the South Mississippi Orchid Society.

Hans-Karl Stauss of Jackson was a guest speaker during American Education Week activities at Chamberlain-Hunt Academy in Port Gibson. Dr. Stauss is an alumnus of the school.

Mert Toler has associated with the hospital emergency department in Clarksdale. He is an internist.

Clyde A. Watkins of Magee was honored with a reception upon his retirement after 30 years as superintendent of Mississippi State Sanatorium. He will assume new duties with the tuberculosis control program of the State Board of Health.

Frank Wiygul, Jr., of Jackson has been elected to a three-year term on the Mississippi Developmental Disabilities Planning and Advisory Council.

Disease Mechanisms Studied at Shreveport

The American College of Physicians (ACP) will sponsor a three-day postgraduate course entitled "Basic Mechanisms of Disease" on Feb. 9-11, 1976, in Shreveport, La. The course, held in conjunction with the Louisiana State University Medical Center School of Medicine in Shreveport, will take place at the center.

The course is intended to review basic mechanisms of internal medicine with emphasis on pathologic physiology. Speakers will review established facts about common problems, and later present current concepts of the mechanism and treatment of these diseases.

The American College of Physicians postgraduate courses have been approved by the American Medical Association Advisory Committee on Continuing Medical Education, and may be used to fulfill Category #1 requirements for the AMA Physician's Recognition Award.

Director of the Shreveport postgraduate course is Dr. M. D. Hargrove, Jr. The course is being planned under the co-direction of Dr. Ronald B. George.

Book Reviews

General Urology. 8th Edition. By Donald R. Smith, M.D. 492 pages with illustrations. Los Altos: Lange Medical Publications, 1975. $10.50.

The book begins with the initial chapters regarding anatomy, embryology, symptoms, physical examination, laboratory, and roentgenographic examination. These chapters are well illustrated and easy to read.

The section on ultrasound examination using the "B" scan with a frequency of 2 MHz is clearly explained and removes a lot of the mystery of this noninvasive technique. Also of interest is the use of the Doppler stethoscope to distinguish acute testicular torsion from epididymitis.

There is an excellent section on radio-isotopic kidney studies including tables of the various radiopharmaceuticals used as well as the differences in radiation detecting instruments such as the Well Counter, probe counter, rectilinear scanner, and the Anger gamma camera.

The chapter on vesicoureteral reflux lucidly describes the anatomy causes and treatment of vesicoureteral reflux. Classification of the configuration of the orifices by Richard P. Lyon is presented. The anatomic concepts of the mesodermal ureterotrigonal unit by Emil Tanagho is clearly illustrated.

The section on immunology of genitourinary tumors is very thought provoking. Plasma carcinoembryonic antigen (CEA) levels are demonstrated in tabular form concerning various malignancies.

Disorders of the adrenal glands are very well written outlining the differential diagnoses and necessary tests.

The chapters on urinary obstruction, nonspecific and specific infections, venereal disease, stones, tumors, and injuries are presented in concise form. The format of listing A, B, C, etc. lends to quick review and summary. There is a current bibliography after each chapter, in case more specific information is required.

The chapter on nonspecific infections of the urinary tract contains an excellent classification of antimicrobial agents and spectra. Other chapters include the diagnosis of medical renal disease, oliguria, chronic renal failure, renal transplantation, disorders of the urinary organs and male genital system, including abnormalities of sexual differentiation.

This book has taken on an international flavor and is now available in Spanish, German, French, Polish, Portuguese, and Japanese.

In summary, the book presents an excellent overview of the entire field of urology. I recommend it as a medical school textbook, as well as an excellent review source for the practicing urologist's program of continuing medical education.

ROBERT F. CARTER, JR., M.D.
Biloxi, Miss.

Annual Review of Allergy 1974. Edited by Claude Albee Frazier, M.D. 442 pages. Flushing, N. Y.: Medical Examination Publishing Company, 1975. $15.00.

The publishers advertise that each new volume deals solely with abstracts, articles, reviews, summaries, commentary and techniques discussed in the past year's literature. There are 49 contributors to this volume. As with all texts with multiple authors there is great variation in the quality of the different sections. The editor not only did not insist on any uniformity of style but also allowed some authors to totally ignore the stated purpose of the book.

Some of the authors diligently reviewed the literature of the past year and then commented upon it. These sections are of excellent quality and are of great value to those primarily interested in allergic diseases.

Other authors primarily wrote essays reviewing specific topics. These authors reviewed the literature over a number of years. Some of these are good and would be of value to a general physician who desired a review of a particular subject.

Some sections of the book are not complete and seem biased. Excerpts from the Bible have frequently been used by those proposing unusual religious beliefs. The medical literature can be used in a similar manner. These sections are of little use to anyone and should not have been printed. Their inclusion is a disservice not only to the readers but also to the other authors.

Annual Review of Allergy 1974 can be recommended for those interested in allergic diseases.

Some sections would be of value to general physicians, but other sources of review material would provide more information with less expenditure of time.

BERNARD H. BOOTH, M.D.
Jackson, Miss.

NEW MEMBERS

ATKINSON, BRUCE E., Amory. Born Greenwood, Miss., Dec. 21, 1946; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1971; interned Parkland Memorial Hospital, Dallas, Tex., one year; internal medicine residency, University Medical Center, Jackson, Miss., 1972-75; elected by Northeast Mississippi Medical Society.

CARMICHAEL, BENJAMIN M., Hattiesburg. Born Atlanta, Ga., July 15, 1939; M.D., Emory University School of Medicine, Atlanta, Ga., 1965; interned Walter Reed General Hospital, Washington, D. C., one year; internal medicine residency, same, 1966-69; cardiology fellowship, Brooke Army Medical Center, San Antonio, Tex., 1969-71; elected by South Mississippi Medical Society.

CATER, ROBERT J., Meridian. Born Meridian, Miss., Jan. 6, 1945; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1970; interned, same, one year; otolaryngology residency, same, 1971-75; elected by East Mississippi Medical Society.

CHIDESTER, LINDA FAY, Mantachie. Born Memphis, Tenn., Aug. 26, 1947; M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1973; interned St. Joseph Hospital, Memphis, Tenn., one year; elected by Northeast Mississippi Medical Society.

DEWEY, THOMAS J., Hattiesburg. Born New Road, La., Aug. 25, 1942; M.D., Louisiana State University School of Medicine, New Orleans, La., 1967; interned Charity Hospital, New Orleans, La., one year; surgery residency, 1968-69; orthopaedic surgery residency, same, 1969-72; elected by South Mississippi Medical Society.

FINEBURG, STEVEN B., Pascagoula. Born Trenton, N. J., April 23, 1946; M.D., Universidad Autonoma de Guadelajara, Mexico, 1972; interned University Beaumont Hospital, Royal Oak, Mich., one year; elected by Singing River Medical Society.

GOUGH, WALTER C., Mound Bayou. Born Pittsburgh, Pa., April 24, 1943; M.D., Meharry Medical College School of Medicine, Nashville, Tenn., 1970; interned Mercy Hospital, Pittsburgh, Pa., one year; pediatric residency, same, 1971-72; pediatric residency, Hubbard Hospital, Nashville, Tenn., 1972-75; elected by Delta Medical Society.

HOLLINGSWORTH, JEFFERSON F., Jackson. Born Meridian, Miss., July 6, 1943; M.D., Tulane University School of Medicine, New Orleans, La., 1968; interned Duke University, North Carolina, one year; surgery residency, same, 1969-70; surgery residency, National Institutes of Health, Bethesda, Md., 1970-72; surgery residency, Stanford University, Stanford, Calif., 1972-75; elected by Central Medical Society.

KELLETT, BOYD A., Hattiesburg. Born St. Johns, Newfoundland, May 31, 1943; M.D., McGill University Faculty of Medicine, Montreal, Canada, 1969; interned Jewish General Hospital, Montreal, Canada, one year; elected by South Mississippi Medical Society.

LONGMIRE, A. W., Pascagoula. Born Centreville, Miss., June 1, 1945; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1972; interned Walter Reed General Hospital, Washington, D. C., one year; elected by Singing River Medical Society.

MASSEY, FRED M., Tupelo. Born Jackson, Miss., Sept. 24, 1944; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1970; interned Emory University & Grady Memorial Hospital, Atlanta, Ga., one year; orthopaedic surgery residency, University Medical Center, Jackson, Miss., 1971-75; elected by Northeast Mississippi Medical Society.

MCCRORY, HENRY ALLEN, Clarksdale. Born Montrose, Miss., Aug. 31, 1940; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1971; ob-gyn residency, same, 1971-74; elected by Clarksdale and Six Counties Medical Society.

SIMMONS, WILLIAM B., Meridian. Born New Orleans, La., May 14, 1946; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1971; interned, same, one year; pediatric residency, same, 1972-74; elected by East Mississippi Medical Society.

WILBURN, FRANK W., Tupelo. Born Hartsville, Tenn., Oct. 31, 1947; M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1972; interned City of Memphis Hospitals, one year; pediatric residency, same, 1973-75; elected by Northeast Mississippi Medical Society.

MSMA Board Holds Fall Meeting

The association's Board of Trustees and General Officers held their regular fall meeting on Dec. 11 in Jackson and acted on a full agenda of business including reports concerning the association's 1976 budget and Medicaid review project. The Board also reviewed current association activities dealing with Medicare reimbursement, implementation of the National Health Planning and Resources Development Act and professional liability.

Based on recommendation by the Council on Budget and Finance the Board approved a 1976 association budget of $554,494 to include CHAMPUS administrative expenses of $173,463 reimbursed by the Department of Defense. CHAMPUS payments for professional services in Mississippi during 1976 are estimated in excess of $3 million.

The Board received a preliminary report from the Committee on Peer Review concerning the committee's Medicaid review project initiated earlier this year in response to a request from the Mississippi Medicaid Commission that the association review the quality and efficiency of services provided by physicians receiving over $100,000 annually in Medicaid payments. The Board directed that the report be released to the Medicaid Commission and that the public be informed of the report's conclusions that the involved physicians were rendering quality care and efficient medical services.

The Board also reviewed the association's legislative recommendations, most of which deal with the growing professional liability crisis in Mississippi. The Board heard reports concerning local medical society legislative meetings on malpractice legislation and endorsement of such legislation by the Mississippi Economic Council, Mississippi Hospital Association and Mississippi Nurses Association.

Among other actions the Board reviewed the current status of development of a "Health System Agency" in Mississippi under requirements of Public Law 92-641, The National Health Planning and Resources Development Act of 1974, and voted to officially endorse the "Mississippi Health Improvement Corporation" HSA application. The Board also reaffirmed the association's recommendation that the Mississippi State Board of Health be designated the "State Health Planning and Development Agency" under requirements of the same act.

A report on the current status of the association's group insurance programs was presented to the Board by Mr. Thomas A. Yates, III, administrator of the programs. Reports on the status of legal action against certain practices of Mississippi chiropractors and the status of professional liability matters considered at the October 1975 Special Session of the House of Delegates were also received by the Board. A special committee of the Board was appointed to deal with the latter and report to the Board at its next meeting.

In other activities, the Board approved the association joining with other health professional groups in sponsoring a "Mississippi Health Care Forum" next year and a "Mississippi Quality of Life Conference in 1977." The Board also received reports concerning new CHAMPUS reimbursement procedures and the association's Council on Medical Education survey of continuing medical education programs.

Infectious Diseases Studied at UMC



In a continuing education course on infectious diseases at the University of Mississippi Medical Center, family physicians concentrated on diagnostic procedures, antimicrobial agents, virology and epidemiology. Participants included, seated, from left, Dr. Frank C. Wade, Magee; Dr. Joe Johnston, Mt. Olive; and, standing, Dr. Marion Green, Holly Springs; Dr. Wayne Cockrell, Magee; and Dr. Edmond Whitfield, Florence. The Division of Continuing Health Professional Education sponsored the two-day intensive course with Mississippi Regional Medical Program support.

Dr. Guyton Receives AHA Research Award

Dr. Arthur C. Guyton, recognized as one of the nation's top medical researchers, received the American Heart Association's foremost prize for scientific accomplishment this November.

Professor of physiology and biophysics and chairman of the department at the University of Mississippi Medical Center, Dr. Guyton accepted the Research Achievement Award at the association's annual meeting in Anaheim, Calif.

His research, spanning more than two decades at the Medical Center, has been focused on understanding the overall philosophy of bodily function, how the body regulates its intrinsic activities automatically day in and day out.

His conclusion that cardiac output was controlled by the function of the peripheral compartment led to a complete reversal in thinking from the previous concepts which had identified the heart as the principle controller of cardiac output.

This reversal had far reaching basic and clinical implications.

As physiologist, mathematician and engineer, he devised precise instruments for calculating scientific findings.

The result is a 400-equation math model of the circulatory system, still being enlarged.

His study of the interstitium led to a new understanding of fluid disturbances in congestive heart failure. No one before him had been able to measure the pressure in this almost inaccessible area.

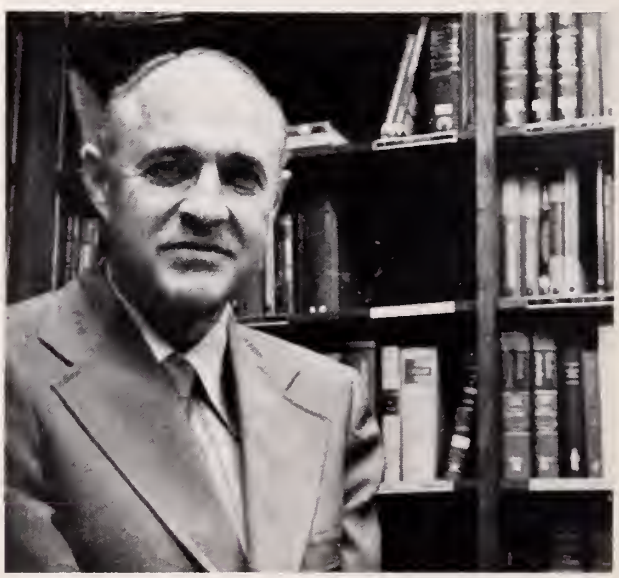
Dr. Guyton also helped establish the value of external heart defibrillation.

The AHA award is not the first recognition of his achievements. The Oxford native received the 1959 Ida Gould Award for cardiovascular research presented by the American Association for the Advancement of Science.

He earned the First Federal of Mississippi Award in 1966 for contributions to his home state.

Last year, he received the teaching award from the Association of Chairmen of Departments of Physiology.

Prior to receiving his M.D. at Harvard Medical School, he graduated first in his class at the University of Mississippi with a major in chemistry and



Dr. Guyton

minors in math and English. This year, he was named to the Ole Miss Hall of Fame.

He has served as president of the American Physiological Society and currently heads the Federation of American Societies of Experimental Biology.

He was prime mover in organizing the Mississippi Heart Association, has served as president, and received its first Distinguished Achievement Award.

Dr. Guyton has served on the American Heart Association's policy committee, publications board, and board of directors.

The author of more than 300 scientific books and papers, Dr. Guyton's *Textbook of Medical Physiology,* now in its fifth edition, is the most widely used physiology text in the world.

Miss. Hospitals Chosen for Cancer Program

A network of Mississippi hospitals and health professionals is one of 10 in the nation chosen to develop a model head and neck cancer control program.

The University of Mississippi Medical Center is recipient of a $185,067 National Cancer Institute grant to develop the project. Only one other institution in the South got a similar grant.

Hospitals and health professionals in six Mississippi cities will work together on the three-year program. Participating institutions are Veterans Administration Center, Mississippi Baptist Hospital, Jackson-Hinds Comprehensive Health Center, and University Hospital, Jackson; Forrest General, Hattiesburg; Southwest Mississippi Regional Medical Center, McComb; Delta Medical Center, Greenville; Lowndes General, Columbus; and F. G. Riley, Meridian.

"The cornerstone of the whole project is that it's a team effort," said Dr. Michael E. Jabaley, UMC professor of surgery and project coordinator. "It involves surgeons, family practitioners, internists, dentists, nurses, dental hygienists, radiotherapists and chemotherapists, rehabilitation professionals, the cancer patient, and the potential cancer victim."

The team of health professionals within the network will study current ways of treating head and neck cancer patients—from detection through rehabilitation. They'll share and analyze data on care methods to find most effective and possible new ways to provide comprehensive treatment for Mississippians.

One new approach will be to teach dental hygienists to examine each patient, under a dentist's supervision, for early signs of head and neck cancer. The Schools of Health Related Professions and Dentistry at the Medical Center have already begun plans for that phase of the program.

"All the UMC schools—medicine, nursing, health related professions, and dentistry—are working together on this project with the network hospitals and their key people," said Dr. Jabaley. "We stress four things: early detection, early diagnosis, coordinated treatment, and rehabilitation."

What happens in the head and neck cancer control program at the Medical Center and the state network of hospitals and health professionals will become part of the National Cancer Institute's Cancer Control Program.

Results will give other communities and states a model coordinated effort to improve the care of patients who develop cancer in this critical area of the body.

Urology Society Plans May 2 Seminar

The Mississippi Urological Society plans to sponsor a postgraduate seminar for family physicians on Sunday afternoon, May 2, preceding the MSMA annual session. The seminar will take place at the Holiday Inn Downtown in Jackson.

The planning committee seeks ideas and suggestions on topics to be presented. Please take a moment, fill out the questionnaire below and return to Dr. William Gates, 501 Leigh Drive, Columbus, Miss. 39701.

I would ( ), would not ( ) be interested in attending a postgraduate seminar on urology, Sunday, May 2, in Jackson.

Topics I would like to have discussed include:

. . . . . .

. . . . . .

Signed . . . . . M.D.

Medical Center Announces New Staff

Two physicians and a microbiologist have joined the faculty of the University of Mississippi School of Medicine as assistant professors.

Dr. Glenda Scallorn is in the Department of Psychiatry and Human Behavior, and Dr. William T. Whitney, Jr., is on the pediatric faculty. Dr. Joe Edgar Humphries is in clinical laboratory sciences.

Dr. Scallorn, a Tupelo native, returned to the Medical Center after a residency and a fellowship at Vanderbilt University Medical Center, Nashville. A Mississippi College alumna, she earned her M.D. degree at the Mississippi medical school in 1970 and did an internship at University Hospital.

Dr. Whitney had been in private practice at Exeter, N. H., since 1969. An A.B. degree graduate of Harvard University, he attended Columbia University and got his M.D. degree at the University of Vermont College of Medicine. He interned at North Carolina Memorial Hospital and did a residency at Strong Memorial Hospital, Rochester.

Dr. Humphries is former director of the plasma center and medical laboratory at Global Laboratories, New Orleans. The B.S. degree graduate of Southwestern State College, Oklahoma, holds M.S. and Ph.D. degrees from Baylor Dental College, Dallas.

DEATHS

MARLAND, THOMAS J., Jackson. Born Chicago, Ill., Sept. 8, 1921; M.D., Marquette University, Milwaukee, Wisc., 1945; interned one year, St. Luke's Hospital, Chicago, Ill.; anesthesiology residency, Charity Hospital, New Orleans, La., two years; died Nov. 17, 1975; age 54.

MORRIS, L. B., Macon. Born Mar. 1, 1899; M.D., Northwestern University Medical School, Chicago, Ill., 1922; interned Ancon Hospital, Canal Zone, one year; member of Fifty Year Club MSMA; died Nov. 21, 1975, age 76.

PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

NSN 6505-00-148-6967

Pinworms, roundworms controlled with a single, non-staining dose of

ANTIMINTH®

(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

*Data on file at Roerig.

Please see prescribing information on facing page.

MMPAC Bats .740

It's official now; the Mississippi Medical Political Action Committee batted .740 in its first venture into Mississippi legislative races.

MMPAC, which until this year had limited its political education and support activities to federal elections, supported legislative candidates in both the 1975 Mississippi primaries and general election.

MMPAC's entrance into the state's legislative races was urged by the MSMA House of Delegates at its 1974 and 1975 meetings.

A primary tool used by the PAC in its political education and support activities during the races was the "Health Voting Index" on members of the 1972-76 Mississippi Legislature developed by MSMA.

MMPAC membership is at an all time high, perhaps indicating the increased interest of physicians and their wives in local governmental affairs, and the PAC will receive a special award for this at the American Medical Political Action Forum to be conducted in Washington in April.

MSMA Files Suit

The Mississippi State Medical Association has filed a suit alleging illegal practices by a chiropractor which are detrimental to the public's health and in violation of the state's chiropractic and medical licensing acts. The suit seeks a judicial interpretation of the Mississippi Chiropractic Licensing Act of 1973 with respect to the use of certain treatment modalities by chiropractors which the MSMA alleges are injurious to the public's health when performed by persons not licensed to utilize them under Mississippi law.

The treatment modalities are drugs, medicines, machines and other medical appliances which are unsafe for purposes of treatment and diagnosis except when prescribed or used under the supervision of a physician duly licensed to practice medicine, surgery or osteopathy.

The suit has been filed in Chancery Court of the First Judicial District of Hinds County, Msisissippi.

Physicians Need to Counsel Smokers

Physicians have a responsibility for more than warning patients about the dangers of smoking. They should help smokers to quit by assisting them in finding meaningful alternatives, even a change in life style, a U.S. Navy Surgeon says.

In the fall issue of "Clinical Notes on Respiratory Diseases," an American Lung Association Christmas Seal publication, Dr. Richard D. Fosburg outlines his own office-centered approach to helping patients kick the habit. Dr. Fosburg is chairman of the department of cardiothoracic surgery, Naval Regional Center, San Diego, Calif. and a captain, U.S. Navy.

"Most patients come into the doctor's office in a highly receptive mood regarding ways to improve their health," Dr. Fosburg says. Thus physicians have a unique chance of making a real impression on the smoker.

Doctors can begin, he says, by prominently displaying "no smoking" signs in their offices, along with anti-smoking posters and self-help literature available from the Christmas Seal people and other health organizations.

Face-to-face with the patient, the doctor stressed that quitting can result in repair of some damage by the body's own recuperative powers.

Many do not realize that when smoking stops, damaged tissue can be restored, Dr. Fosburg says.

He recommends the "Smoker's Self-Testing Kit," to help assess individual reasons for smoking, what kind of smoker the patient is, and whether or not he or she really wants to quit. The kit is a government publication available through the lung association.

"Becoming a nonsmoker is marvelously enhancing of self-image," Dr. Fosburg says. By capitalizing on personal interests, doctors can suggest meaningful alternatives to the cigarette, and new pleasures.

He suggests graduated forms of exercise for improved physical well-being, bicycle riding and dancing, cutting down on alcohol intake, and tips for losing, rather than gaining, weight. For improved sensory awareness, he suggests carrying pictures to look at, or a transistor radio to listen to when the urge to smoke appears. Doctors also can help patients reduce some tensions that lead to smoking by encouraging changes in life style.

Although time is "the enemy" in counseling patients about smoking, delving into private needs and attitudes is necessary for success, Dr. Fosburg says. Physicians should strive to provide total care for the total person, and anti-smoking counseling can be combined with other suggestions about the person's physical well-being.

Dr. Fosburg's article, "Help Your Patients Become Non-Smokers," and information about the "Smoker's Self-Testing Kit" is available from the

American Lung Association, 1740 Broadway, New York, N.Y. 10019, or by asking the Mississippi Lung Association for the fall 1975 issue of "Clinical Notes on Respiratory Diseases."

Pediatric Intensive Course Held



Children and their diseases got top priority in a week-long pediatric intensive course at the University of Mississippi Medical Center. Participants included, seated, from left, Dr. Rosalina Aquilar, Philadelphia; Dr. J. M. Montalvo, UMC professor of pediatrics and course coordinator; Dr. John Harper, Taylorsville; Dr. Earl Perrett, Demopolis, Ala.; and, standing, Dr. John Harris, Okolona; Dr. L. Z. Broadus, Purvis; Dr. E. J. Schmidt, Bude; Dr. W. E. Birdsong, Jasper, Ala.; Dr. William P. Thompson, Yazoo City; and Dr. Gordon McHenry, Wiggins. The course is one in a series of refresher studies the UMC Division of Continuing Health Professional Education offers with Mississippi Regional Medical Program support.

Dr. Bolten Is Given Posthumous Award

The late Dr. Karl A. Bolten of Jackson has been posthumously named first recipient of the American Society for Colposcopy and Colpomicroscopy Hinselmann Award.

Dr. Bolten was associate professor of obstetrics-gynecology at the University of Mississippi Medical Center at the time of his death in April 1972.

Named for the man who originated colposcopy in in 1925 in Hamburg, Germany, the medal for outstanding work in the field will be given every two years. In addition to the medal, the award included a $500 check to the widow of this year's recipient.

Dr. Bolton was named recipient at the ASCC annual meeting. He served as president of the organization in 1967.

Colposcopy has been widely used in Europe and South America to detect uterine cancer in its early stages. Dr. Bolten, a native of Bonn, Germany, who got his M.D. degree at the University of Jena (Germany), established the technique in the United States.

He came to the U.S. in 1952 to do a fellowship in ob-gyn at Jefferson Medical College, Philadelphia, Pa., and joined the Mississippi medical school faculty in 1960.

Dr. Bolten authored or contributed to three books and numerous papers on colposcopy. A founding member of the World Association for Gynecological Cancer Prevention, he was the U.S. representative to the International Colposcopy Congress and an American College of Obstetricians and Gynecologists-selected lecturer at the World Congress of Ob-Gyn in 1964.

Anatomic Pathology Studied in Miami

An anatomic pathology seminar will be held Jan. 23-25 at the Deauville Hotel in Miami Beach. The program is acceptable for AMA Physician's Recognition Award Category I credit.

Guest faculty will be Drs. Charles B. Carrington, Robert G. Freeman and John H. Yardley.

For information write Division of Continuing Medical Education, University of Miami School of Medicine, P. O. Box 520875, Biscayne Annex, Miami, Fla. 33152.

Practical Modern Neurology Course Set

A course on practical modern neurology is set for Feb. 2-6 at the Hotel Fontainebleau in Miami Beach.

This course is designed to provide practical and useful approaches to the management of common neurological problems. The course will consist of a minimum of 28 hours of lectures, demonstrations and discussions.

For information write Division of Continuing Medical Education, University of Miami School of Medicine, P. O. Box 520875, Biscayne Annex, Miami, Fla. 33152.

NHI Is in Lull

The National Health Insurance hearings on Capitol Hill have been marked so far by a notable lack of excitement or sense of urgency. The national news media ignored the first legislative hearings of the session on NHI, underscoring contentions by many witnesses that the public doesn't rate NHI high on its scale of worries or interests.

Nonetheless, a recently announced decision of the House Interstate and Foreign Commerce Committee's Subcommittee on Health to conduct NHI hearings, brings into the open anew the odd jurisdictional dilemma that perplexes Congress in its quest for action on NHI. Rep. Paul Rogers (D. Fla.) has announced his House Commerce Subcommittee on Health will start NHI hearings. He plans to call first the chief Congressional sponsors of the major NHI bills to testify. Rogers is telling the House Ways and Means Committee in unmistakable terms that he wants a piece of the NHI action, perhaps the big piece.

The Ways and Means Subcommittee on Health, headed by Rep. Dan Rostenkowski (D.Ill.), ends hearings on NHI just as Rogers gets started. Relations between the rival panels and their staff members are strained.

Since Ways and Means traditionally has had prime jurisdiction, the chief sponsors of the NHI bills in the House are for the most part members of the Ways and Means Committee. Examples include Ways and Means Chairman Al Ullman (D. Ore.), sponsor of the American Hospital Association's plan, Rep. John Duncan (R. Tenn.), a chief sponsor of the American Medical Association's NHI proposal, Rep. Omar Burleson (D. Texas), foremost House backer of the Health Insurance Companies' measure, and Rep. James Corman (D. Calif.), sponsor of Labor's Health Security Act.

None are anxious to go before the Rogers' Subcommittee in behalf of their bills, thus lending support to Rogers' jurisdictional claim.

The way health jurisdiction has been parcelled out in the House this year, Rogers can lay valid claim to much of the benefit and structural side of NHI legislation while Ways and Means has acknowledged hold on all tax financing aspects. But the question remains: Can these be separated? Most believe they can't and that some special joint-committee setup will have to be formed to avoid a divisive squabble in the House pitting one major committee against another.

Tri-State Thoracic Conference Set

Ten speakers from medical centers throughout the United States will be featured at the 20th Annual Tri-State Thoracic Consecutive Case Conference to be held Jan. 23-24, 1976, at the Sheraton Hotel in Biloxi.

Dr. John R. Williams of Greenville, president of the Mississippi Thoracic Society, announced that the two-day event, designed to serve as a postgraduate training session for physicians, residents and interns, will be sponsored by the lung associations and thoracic societies of Mississippi, Louisiana, and Alabama.

Mississippi physicians featured on the program include Dr. John D. Morgan of McComb and Dr. John R. Williams of Greenville. Dr. Roland B. Robertson, Jr. of Jackson, program chairman for Mississippi, will serve as moderator.

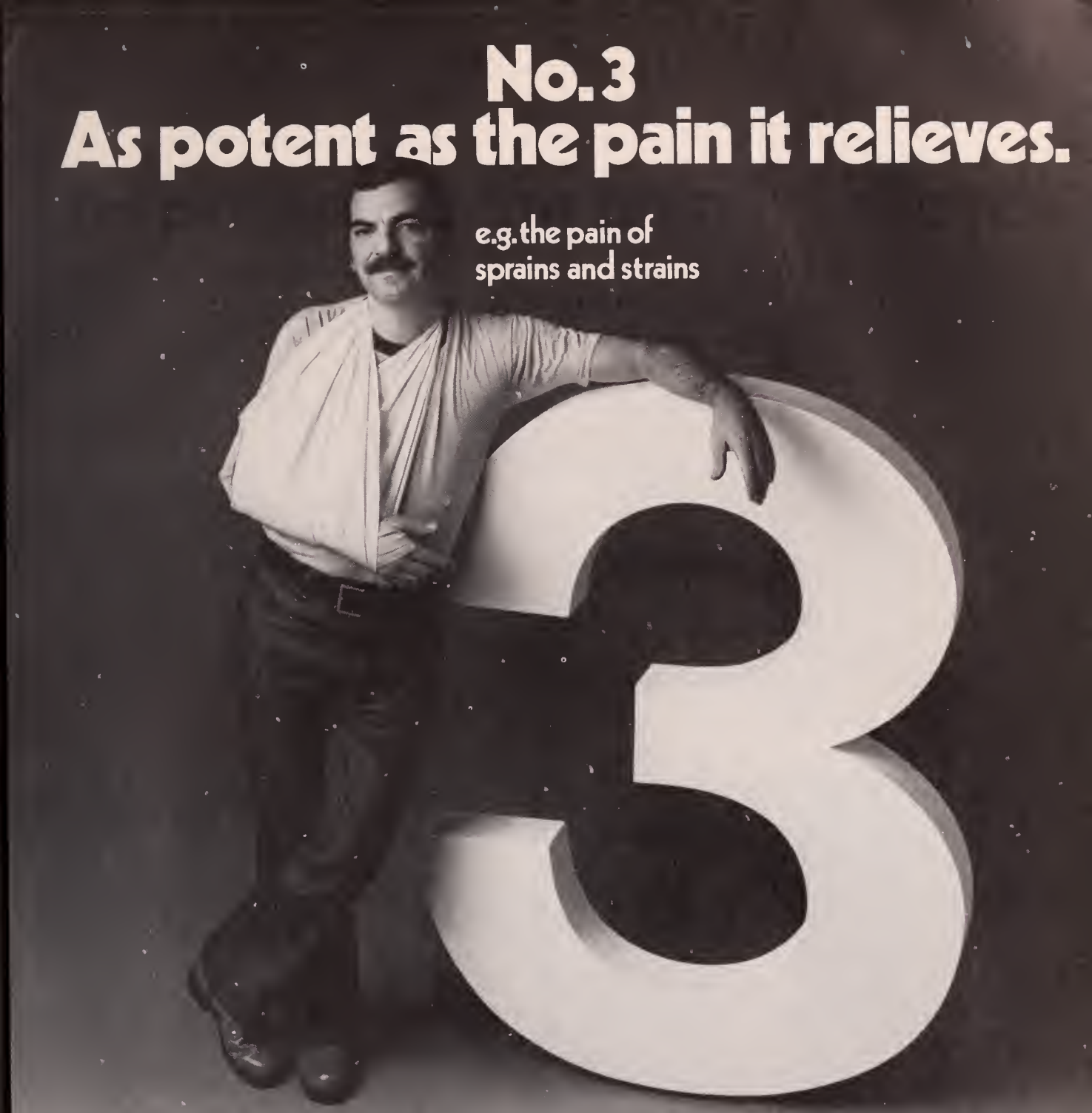
Guest discussants for the conference will be Dr. Edward Gaensler, professor of surgery, Boston University School of Medicine; Dr. Lee F. Rogers, chairman, radiology department, Northwestern University School of Medicine, Chicago; and Dr. Benjamin Burrows, professor of medicine and director, division of respiratory sciences, University of Arizona College of Medicine. Other program participants include Dr. Frank Connery and Dr. Richard Champion of Birmingham; Dr. Seymour Ochsner, Dr. Dean Ellithorpe, and Dr. Robert Jones of New Orleans.

Topics of special interests to thoracic specialists to be presented include: "Consecutive Cases of Pulmonary Embolism," "Mycobacterial Disease," "Oat Cell Carcinoma," "Bronchoalveolar Cell Carcinoma," "Pre- and Post-Surgical Headaches" and "Diffuse Lung Disease."

Serving on the program planning committee are: Dr. William Bailey, Birmingham; Dr. Hurst B. Hatch of New Orleans; and Dr. Roland B. Robertson, Jr., of Jackson.

Registration fee is $20. For registration forms and additional information, contact the Mississippi Thoracic Society, P. O. Box 9865, Jackson, Miss. 39206.

No. 3
As potent as the pain it relieves.



NOT TOO LITTLE

- as potent as the pain you need to relieve in patients with fractures, sprains, strains, wounds, contusions, and the pain of surgical convalescence
- unlike acetaminophen/codeine combinations, it does not sacrifice anti-inflammatory action

NOT TOO MUCH

- potent—yet not excessive
- addiction liability low

NOT TOO EXPENSIVE

- brand-name quality, yet reasonable in cost
- readily available in both hospital and local pharmacies

CIII CONVENIENCE

- telephone Rx in most states, up to 5 refills in 6 months at your discretion (where state law permits)

EMPIRIN® COMPOUND WITH CODEINE NO. 3

codeine phosphate* (32.4 mg) gr ½
Each tablet also contains: aspirin gr 3½, phenacetin gr 2½, caffeine gr ½. *Warning—may be habit-forming

Wellcome | Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Effectiveness across the spectrum of most common forms of insomnia

Awake too long, awake too often, awake too early...

These are the most common forms of insomnia, and may occur singly or in any combination. The night of troubled sleep depicted here comprises all three types. As the night progresses from left to right, each sleep stage is identifiable by its own shade of gray. Blue represents "Awake."

As you can see, this hypothetical "patient" takes well over an hour to fall asleep, awakens several times during the middle of the night and awakens too early in the morning.

Sleep Stages

- Awake
- REM
- Stage 1
- Stage 2
- Stage 3
- Stage 4



Awake too long

Awake too often during the night

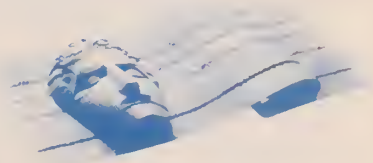
The insomnias most often occurring in young and older adults

For patients with trouble falling asleep (common in young adult insomnia patients), Dalmane (flurazepam HCl) 30 mg provides sleep within 17 minutes, on average. For those with trouble staying asleep or sleeping long enough (common in those over 50), Dalmane offers increased total sleep time with fewer nocturnal awakenings. These clinical results were demonstrated in studies conducted in four geographically separated sleep research laboratories.[1-4]

The relative safety of Dalmane (flurazepam HCl) is well documented

Dalmane (flurazepam HCl) is relatively safe and well tolerated; morning "hang-over" has been infrequent. The usual adult dosage is 30 mg; in elderly or debilitated patients, limit initial dosage to 15 mg to preclude over-sedation, dizziness or ataxia. Caution patients about possible combined effects with alcohol and other CNS depressants.

Broad-spectrum medication for the most common forms of insomnia



7 Hours



Awake too early

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.

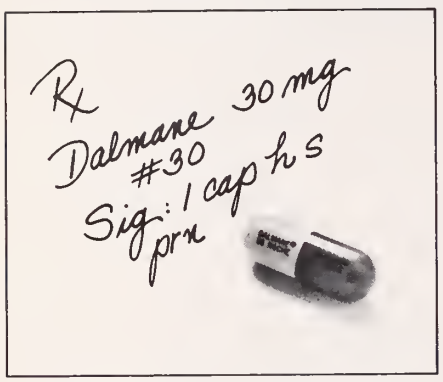
- ☐ induces sleep rapidly
- ☐ reduces nighttime awakenings
- ☐ lengthens total sleep time

ROCHE

Please see following page for a summary of complete product information.

Broad-spectrum medication for the most common forms of insomnia

Dalmane®
(flurazepam HCl) ℞ IV



Objectively proved in the sleep research laboratory, Dalmane

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- provides 7 to 8 hours sleep, on average, without repeating dosage

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES:

1. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971

2. Frost JD Jr: A system for automatically analyzing sleep. Scientific exhibit at the 24th Clinical Convention of the American Medical Association, Boston, Nov 29-Dec 2, 1970; and at the 42nd annual scientific meeting of the Aerospace Medical Association, Houston, Apr 26-29, 1971

3. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

4. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ



ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Medico-Legal Briefs

COMMUNITY HOSPITAL MAY NOT LEASE OFFICE TO PRIVATE PHYSICIAN

A community hospital was not authorized to lease part of its facilities to a surgeon engaged in private practice, the Mississippi Supreme Court ruled.

The hospital was owned jointly by a county and a city. The hospital renovated and converted part of a building formerly used as nurses' quarters into private office facilities leased to the surgeon for $300 a month. Several physicians who owned a medical clinic brought an action challenging the hospital's expenditures on the space for the physician. A trial court enjoined the hospital from leasing to the physician for his private practice, and the hospital appealed.

On appeal, the Mississippi Supreme Court agreed that neither the owners nor the operators of the hospital had the authority to expend public funds to convert the nurses' home to private office facilities for physicians in private practice. The physicians, as taxpayers and as competitors with office space for lease, had standing to bring the suit, the court added. Sympathizing with the hospital's desire to obtain qualified physicians, the court said that any remedy must come from the legislature.

The trial court's judgment was affirmed. Conceding that the hospital had no authority to lease space to the surgeon, two justices argued that the physicians had no standing to bring the suit.—*Prichard v. Cleveland,* 314 So.2d 729 (Miss.Sup.Ct., May 19, 1975)

Virgin Islands Clinical Conference Set

The First Mid-Winter Virgin Islands Clinical Conference will be held in St. Thomas, Jan. 29-31, 1976, by the U. S. Virgin Islands Medical Society in association with the faculty of the University of Pennsylvania School of Medicine.

This program is acceptable for 14 credit hours in Category 1 for the Physician's Recognition Award of the AMA, and will include lectures and seminars of interest to the physician in general practice, internal medicine, general surgery and ob-gyn.

For further information, write to: Dr. Harold A. Hanno, Secretary, U. S. Virgin Islands Medical Society, Box 1442, St. Thomas, Virgin Islands 00801.

MSMA Endorses The MHIC

The association has officially endorsed the application of the Mississippi Health Improvement Corporation for funding as the Health Systems Agency for Mississippi under requirements of Public Law 93-641, The National Health Planning and Resources Development Act of 1974. Among the initial board members of the MHIC were the following physicians: Drs. Guy D. Campbell, Jackson; Norman C. Nelson, Jackson; T. D. Lampton, Jackson; Arthur A. Derrick, Durant; Foster Lowe, McComb; and Alfio Rausa, Greenwood. The Board was expanded to 51 members in December and has geographic, consumer, professional, ethnic, public and minority representation as required by Public Law 93-641. At this time, the only other applicant for HSA funding is the Mississippi Health Systems Agency whose incorporators are Mr. Fred St. Clair, director, Mississippi Optometry Association; Mr. Paul Brown, staff member, Mississippi Council on Aging; and Mr. Joe Yates, an attorney in Batesville.

Your Son or Daughter Is Your Family's Ticket to America

Your son or daughter in high school can provide a way for your entire family to learn more about the United States—and have fun doing it.

Contact:

AFS

Bicentennial Exchange
313 East 43rd Street
New York, N.Y. 10017

New Orleans Graduate Assembly Scheduled

The 39th annual New Orleans Graduate Medical Assembly will be held Mar. 29-April 1 at the Fairmont-Roosevelt in New Orleans.

The program is accredited for continuing education hours by the American Academy of Family Physicians and the American College of Emergency Physicians.

For further information, contact Mrs. Louise Neary, Executive Director, 1430 Tulane Avenue, New Orleans, La. 70112.

Patient Counselling Congress Set

The Excerpta Medica Foundation announces the convening of the first international congress on patient counselling, April 21-23, 1976, in Amsterdam, The Netherlands.

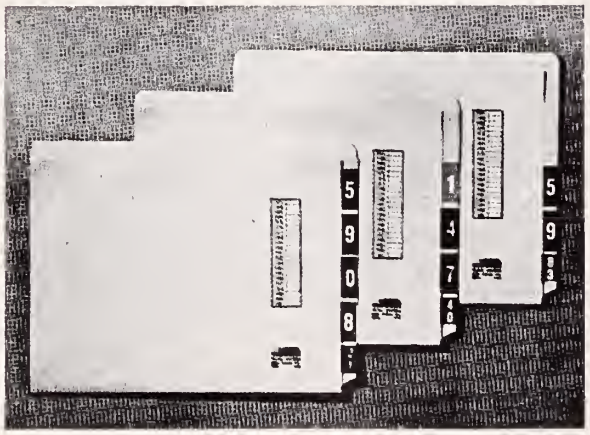
Plenary sessions will deal with the following subjects: Should the patient be told the truth?; doctor awareness of patient counselling needs; techniques of patient counselling; legal aspects of being a patient; patient counselling in psychiatric illness; labelling of drugs; influence of the mass media on patient behaviour; and patient counselling as the beginning of social action.

Sectional sessions will be devoted to the following topics: Patient counselling in hospital treatment; patient counselling in chronic diseases; death and dying; communicating with the mentally retarded; adjustment to loss of major body function; patient counselling and the general practitioner; patient counselling as a part of medical training; the role of the health professional in patient counselling; patient counselling in paediatrics; and patient counselling in geriatrics.

For further details write First International Congress on Patient Counselling, c/o Excerpta Medica Foundation, P. O. Box 1126, Amsterdam, The Netherlands.

WHY OUR COLOR CODED FILING SYSTEM?

REDUCES FILING TIME
ELIMINATES MIS-FILES
NO NEED TO REPLACE YOUR PRESENT FOLDERS



PRINTING — OFFICE DESIGN, FURNITURE & SUPPLIES

Mississippi Stationery Company

277 East Pearl Street — Jackson, Mississippi 39201

FOR MORE INFORMATION
CALL COLLECT (601) 354-3436

Mississippi, Louisiana Internists Meet

Specialists in internal medicine and related medical fields will hold a two-day scientific meeting on Jan. 30-31, 1976, at the University Medical Center in Jackson.

Physicians who attend the regional meeting are eligible for credit toward the American Medical Association Physician's Recognition Award in Category 1. All physicians are invited to attend.

In charge of arrangements for the Mississippi/Louisiana Regional Meeting is Dr. Guy D. Campbell, Jackson, who serves as the ACP's representative in Mississippi.

Family Medicine Review Set

The Sixth Family Medicine Review, Session III, will be held Feb. 22-28, 1976, at the University of Kentucky Medical Center, Lexington. Registration fee is $245.00.

For further information, contact: Dr. Frank R. Lemon, Continuing Education, College of Medicine, University of Kentucky, Lexington, Ky. 40506.

CLASSIFIED

INTERNIST needed for a four man well established group in Memphis, Tennessee. Openings available immediately and in January and July of 1976. Modern office is adjacent to Methodist South Hospital (a satellite of Methodist Hospital Central of Memphis, a 900 bed accredited facility). Our practice is one of general internal medicine with an emphasis on cardiology, however, opportunity exists for any major sub-specialty. Affiliation with the University of Tennessee School of Medicine is available if desired.

JOIN MPAC TODAY

Index to Advertisers

Adolescent Care Unit 11

Blue Cross-Blue Shield of Miss. 8
Burroughs Wellcome Co. 28A

Canton Exchange Bank 6
Coca-Cola 11

Hill Crest Hospital 12
Hyrex-Key Pharmaceuticals 15

Internist Needed 19

Eli Lilly and Co. ..... front cover

Mallinckrodt, Inc. 7, 4A, 14B, 14C
Mead Johnson Laboratories 14

Miss. Stationery Co. 30

Pharmaceutical Manufacturers Assoc. 12D, 13
Premier Printing Co. 11

Roche Laboratories
.... second cover, 3, 28B, 28C, 28D, third and fourth covers
Roerig, a Division of Pfizer Pharmaceuticals . 12A, 24, 25

The Upjohn Company 12B, 12C

U. S. Air Force 18

Volunteers of America 10

Webcon Pharmaceuticals 16, 17

Thomas Yates and Co. 4

IN CONCLUSION

Pharmaceutical industry spending on research and development more than doubled between 1965 and 1974 -- with inflation and tightening regulatory controls accounting for most of the increase -- but there has been no real increase in research and development commitment since 1970, according to an economic analysis released by the Pharmaceutical Manufacturers Association. The decline is felt to be the result of the negative impact of the 1962 amendments to the FD and C act. After accounting for inflation, drug companies only increased research spending projects by 56 per cent between 1965-74.

The Commission on Professional and Hospital Activities (CPHA) announces publication this February of Hospital Mortality, PAS Hospitals, United States, 1972-73, the first book in a new reference series. For the first time, this book makes available in-hospital fatality rates and length-of-stay information for all patients discharged from short-term, nonfederal U.S. hospitals participating in the Professional Activity Study. Data displayed in Hospital Mortality have been compiled on more than 24,000,000 individual patients.

The American Retired Physicians Association is being organized to serve special interests and needs of retired and semi-retired physicians, their spouses, and widows. The association was recently incorporated in Illinois as a non-for-profit group. Membership services include newsletter, group tours, special purchases of major consumer items and information of interest to retirees. Physicians aged 55 and over, spouses and widows are eligible; annual dues of $10 will cover both physician and spouse.

Incidence of head and body lice among Mississippians in all areas of the state has reached epidemic proportions, according to Dr. Durward Blakey, chief, Bureau of Disease Control, Mississippi State Board of Health. He added that the infestations are no respecters of socioeconomic status and school settings are no more likely to spread the disease than other areas of social contact. Lice infestation is always present, but rises to a peak about every ten to thirteen years, he said. We are now approaching the peak in the current cycle.

Accreditation reports of the Joint Commission on Accreditation of Hospitals will remain confidential as a result of a consent decree filed in U.S. District Court in Chicago in which HEW agreed to stop making public the documents supplied to it by the JCAH for use in validation studies. In the settlement, HEW agreed that, by law, accreditation letters, accompanying recommendations and comments are confidential; JCAH agreed to continue supplying HEW with the reports as long as they are kept confidential.

LIBRIUM®
(chlordiazepoxide HCl)

FOR ALL THE RIGHT REASONS.

- prompt and specific action
- documented benefit-to-risk ratio
- three dosage strengths to meet most therapeutic needs



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)
Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

LIBRIUM®
chlordiazepoxide HCl/Roche
5 mg, 10 mg, 25 mg capsules

Please see following page.

LIBRARY
JAN 14 1976
NEW YORK ACADEMY OF MEDICINE

N.Y. ACADEMY OF MED
EAST 103RD ST
EW YCRK N.Y.
1C029

LIBRIUM®
(chlordiazepoxide HCl)

FOR ALL THE RIGHT REASONS.

Yesterday's decision to use Librium for a clinically anxious patient was based on several good reasons. Safety. Effectiveness. Versatility. And the reasons you chose it yesterday are as valid today.

Librium has accumulated an unsurpassed clinical record. A record validated in several thousand papers published both here and abroad.

Librium, when used in proper dosage, rarely interferes with a patient's mental acuity or ability to perform. However, as with all CNS-acting agents, good medical practice suggests that patients be cautioned against hazardous activities requiring complete mental alertness.

Librium has an established safety record and a documented benefit-to-risk ratio. And Librium is used concomitantly with such drugs as cardiac glycosides, diuretics, anticholinergics and antacids.

So when you consider antianxiety therapy, consider Librium. It's a good choice. For today. And tomorrow.



ROCHE

PROVEN ADJUNCT FOR CLINICAL ANXIETY

LIBRIUM® C IV

chlordiazepoxide HCl/Roche

Please see preceding page for summary of product information.

ALCON

AMERICAN REVOLUTION BICENTENNIAL 1776-1976

JOURNAL OF THE Mississippi STATE MEDICAL ASSOCIATION

FEBRUARY 1976

BECOTIN®
Vitamin B Complex

BECOTIN® with VITAMIN C
Vitamin B Complex with Vitamin C

BECOTIN®-T
Vitamin B Complex with Vitamin C, Therapeutic

MI-CEBRIN®
Vitamins-Minerals

MI-CEBRIN T®
Vitamin-Minerals Therapeutic

AND A WIDE VARIETY OF OTHER PHARMACEUTICALS

DISTA

DISTA PRODUCTS COMPANY
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

400944

This Month . . . Temporal Bone Surgery, Urinary Stone Management, Pulmonary Overaeration in Infancy

M.S.M.A.

Both often



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



"I do not believe you can do today's job with yesterday's methods and be in business tomorrow." Nelson Jackson

Dr. Nathaniel Chapman, as brilliant as he was in his day, could not survive in today's complex business world. His methods and business procedures belong in the 19th century. TODAY'S PROBLEMS SHOULD BE SOLVED BY TODAY'S METHODS.

Unlike Dr. Chapman, you have Systemedics to help you solve today's complex medical practice problems. We'll be happy to show you how our system creates in-office efficiency and collects more money for you. It will please you while eliminating clerical drudgery in your office.

Your staff need only send in a daily voucher on each patient served. We'll handle the rest.

Act now—why wait. Install today's methods and realize the many benefits now being enjoyed by the thousands of doctors on the Systemedics system.

Let us show you how this will more than pay for itself through increased collections—collection of receivables that you couldn't previously identify or collect.

Systemedics/AMS

P O BOX 191, LAUREL, MISSISSIPPI 39440
PHONE (601) 425-2815

Send information about your services.

Name

Address

City State

Telephone

College of Surgeons Meets in Boston

The fourth annual spring meeting of the American College of Surgeons will be held April 26-29, 1976, at the Sheraton-Boston Hotel and the Statler Hilton Hotel in Boston.

The courses to be offered and course chairmen are: Surgical Infections and Antibiotics, John F. Burke, Boston, and Stanley M. Levenson, Bronx, NY; Endocrine- and Hormone-Producing Tumors, Richard C. Karl, Hanover, NH, and George R. Prout, Jr., Boston; Duodenal Ulcer Disease, Robert E. Condon, Milwaukee, and Josef E. Fischer, Boston; The Cervical Spine: Injuries, Disc Lesions, Spondylosis, Charles A. Fager, Boston, and Robert G. Ojemann, Boston; Fluids, Electrolytes, and Acid-Base Balance, James H. Duke, Jr., Houston, TX, and Alfred P. Morgan, Jr., Boston; Hematologic Problems in Surgery, Edwin W. Salzman, Boston, and Seymour I. Schwartz, Rochester, NY; Thoracic Trauma and Pulmonary Insufficiency, R. Adams Cowley, Baltimore, and Robert L. Berger, Boston; and Orthopaedic Surgery—Hand Injuries, Ankle Injuries and Back Pain 1976, Thomas B. Quigley, Boston, and J. Drennan Lowell, Boston.

There will also be a number of general lectures, panel discussions, and symposia covering such topics as disseminated breast cancer, the federal government and the surgical profession, biliary tract surgery, and peripheral vascular disease.

Fellows of the college whose dues are paid for 1975, members of the ACS Candidate Group, and surgical residents and interns may register free of charge. The fee for Fellows whose 1975 dues have not been paid, for applicants for Fellowship and for guest physicians is $55. Non-Fellows in federal service (fulltime) or those residing outside the U.S. or Canada may register for $30.

Registered nurses and medical students may attend the general sessions free of charge, but are not eligible to register for postgraduate courses.

The fee for each of the eight postgraduate courses is $50, regardless of the status of the registrant and includes a manual. For registration forms write to S. Frank Arado, American College of Surgeons, 55 E. Erie Street, Chicago, IL 60611.

Volume XVII
Number 2
February 1976



JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

• EDITOR
W. MONCURE DABNEY, M.D.

• ASSOCIATE EDITORS
GEORGE H. MARTIN, M.D.
MYRON W. LOCKEY, M.D.

• MANAGING EDITOR
NOLA GIBSON

• PUBLICATIONS COMMITTEE
LAWRENCE W. LONG, M.D.
Chairman
FRANK L. BUTLER, JR., M.D.
T. A. BAINES, M.D.
and the editors

• THE ASSOCIATION
JACK A. ATKINSON, M.D.
President
LYNE S. GAMBLE, M.D.
President-Elect
JAMES P. SPELL, M.D.
Secretary-Treasurer
C. D. TAYLOR, JR., M.D.
Speaker
R. F. TRIPLETT, M.D.
Vice Speaker
CHARLES L. MATHEWS
Executive Secretary
H. CODY HARRELL
Assistant Executive Secretary

THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION is owned and published monthly by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, $15.00 per annum; $2 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

CONTENTS

ORIGINAL PAPERS

Modern Temporal Bone Surgery—Finding the Key **31** GALE GARDNER, M.D., Memphis, TN

A Review of Management of Patients with Urinary Stones at the North Mississippi Medical Center **36** JOHN P. ELLIOTT, JR., M.D., JAMES O. GORDON, M.D., JOHN W. EVANS, M.D., and LUCAS PLATT, M.D., Tupelo, MS

SPECIAL ARTICLES

Radiologic Seminar CLIX: Pulmonary Overaeration in Infaney **39** BERNARD I. BLUMENTHAL, M.D., Jaekson, MS

A Review of the Mississippi PSRO Screening Criteria for Diabetes Mellitus **44** Mississippi Foundation for Medical Care

EDITORIALS

Management of Head and Neck Tumors **49** MYRON W. LOCKEY, M.D., Jaekson, MS

Dramatie Change Oecurs in Medical Edueation **49** CHARLES L. MATHEWS, Jaekson, MS

THIS MONTH

The President Speaking **48** The Credibility Gap
Medical Organization **57** New State Administration Begins

Copyright 1976, Mississippi State Medical Association



Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

consider the effect on coexisting glaucoma when you prescribe a vasodilator*



a vasodilator that has not been reported to raise intraocular pressure

VASODILAN®
(ISOXSUPRINE HCl)

TABLETS, 20 mg.

the compatible vasodilator

Mead Johnson LABORATORIES

© 1970 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL-54118

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

NEWSLETTER

February 1976

Dear Doctor:

The Mississippi Hospital Association has endorsed the lifesaving program of the Medic Alert Foundation International and will work to extend the unique emergency medical identification system to individuals needing its protection. C. Chandler Clover, chairman of the MHA board of governors, said Medic Alert is a nonprofit, charitable and tax-exempt foundation providing protection for people with hidden medical conditions.

> Medic Alert is designed to speak for the person unable to communicate or unconscious. Members wear an emblem designating medical conditions such as allergy to penicillin, diabetes, heart disease, taking anticoagulants and wearing contact lenses, plus the emergency answering service number.

A National Commission on the cost of medical care will be convened by the AMA to determine the causes of increased medical care expenditures and to review optional courses for public and AMA policy in coping with rising costs. The 10-member interorganizational commission will be composed of representatives from the health field, industry and the public.

A record $547 was spent by the average American on health care in fiscal 1975, says the Social Security Administration. Nation's total expenditure of $118.5 billion during the year ending last June was 13.9% above the previous year. Public spending reached almost $50 billion, or 42% of the total, primarily through Medicaid and Medicare. Hospital care was 39% of total and M.D. services 19%.

Some 37 new drugs were introduced in the U.S. during 1973-4, "an encouraging improvement," reports Paul de Haen in JAMA. Some represent real advances in therapy; others enable the physician to vary his therapeutic regimen, he said. Of the 37 new products, 25 came from American research labs. The gestation period of a new drug is now between five and seven years.

A 10% gain in sustaining members during 1975 was announced by the American Medical Political Action Committee. Urging personal involvement in politics by all delegates, AMPAC chairman J. P. MacLaggan, San Diego, said recent campaign reform legislation makes voluntary participation by physicians more important than ever. AMPAC achieved a record membership in 1975 for the eighth straight year.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

MEC Supports Malpractice Legislation

The Mississippi Economic Council has recommended legislation to resolve the medical malpractice insurance crisis after examining the crisis from the standpoint of its effect on the consumer.

A special committee of the MEC, chaired by Dr. Dewey H. Lane, Jr., of Pascagoula, recently issued its report on the malpractice crisis after several months of study and particularly noted that the growing malpractice crisis will affect the cost and delivery of health care in Mississippi.

The several legislative proposals recommended by the MEC special committee included proposals to reduce the present statute of limitations and to establish medical review panels. Similar proposals have also been recommended by MSMA, the Mississippi Hospital Association and the Mississippi Nurses Association.

Medicare Will Adjust Professional Fees

Physicians in Mississippi and other states where Medicare carriers applied an economic index to fiscal year 1976 prevailing screens will receive an adjustment in professional fees.

In one of its last actions before adjournment in 1975, Congress provided that the economic index applied to Medicare prevailing screens in this fiscal year could not result in a lowering of physicians' professional fees below those authorized for fiscal year 1975. A retroactive adjustment will be made in all claims in which the difference in the amount of payment due is equal to or exceeds $1.00.

Application of an economic index to Medicare prevailing screens was authorized by Congress in 1972. Because of wage-price controls on physician fees which did not end until 1974, the economic index was not applied until July 1, 1975. At that time the Social Security Administration, through the Secretary of H.E.W., interpreted the index as being applicable to prevailing screens authorized in fiscal year 1973, and, as a result, many Medicare carriers lowered reimbursement for physicians' services during fiscal year 1976 below that authorized for fiscal year 1975.

for the inflamed phase of hemorrhoidal flare-up

Anusol-HC® Cream: Rx only. Each gram contains: Hydrocortisone Acetate 5.0 mg; Bismuth Subgallate 22.5 mg; Bismuth Resorcin Compound 17.5 mg; Benzyl Benzoate 12.5 mg; Peruvian Balsam 17.5 mg; Zinc Oxide 110.0 mg. Also contains the following inactive ingredients: propylene glycol, bismuth subiodide, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil and glyceryl monostearate. Non-staining.

Anusol-HC® Suppositories: Rx only. Each contains: Hydrocortisone Acetate 10.0 mg; Bismuth Subgallate 2.25%; Bismuth Resorcin Compound 1.75%; Benzyl Benzoate 1.2%; Peruvian Balsam 1.8%; Zinc Oxide 11.0%. Also contains the following inactive ingredients: bismuth subiodide, calcium phosphate, and coloring in a bland, hydrogenated oil-cocoa butter base.

CAUTION: Federal law prohibits dispensing Anusol-HC® Cream and Anusol-HC® Suppositories without prescription.

for the maintenance and protection phase

Anusol Suppositories and Ointment: Except for hydrocortisone acetate, these forms contain the same percentages of active ingredients as listed above.

Contraindications: History of sensitivity to any component. Topical corticosteroids should not be employed in tuberculous, fungal and most viral lesions of skin (including herpes, vaccinia and varicella).

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy they should not be used unnecessarily on extended areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment. When there is bacterial skin infection, topical corticosteroids should be used only with appropriate concomitant anti-microbial therapy. Prolonged or excessive use of corticosteroids might produce systemic effects.

Dosage and Administration: Anusol-HC Cream: *Adults*—Remove tube cap and attach the plastic applicator. After gentle bathing and drying of the area, apply to the exterior surface and gently rub in. For internal use, insert the applicator by applying gentle, continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories or Ointment.

Anusol-HC Suppositories: One suppository in the morning and one at bedtime, for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol.

Anusol Suppositories: One in the morning, one at bedtime; and one immediately following each evacuation.

Anusol Ointment: Apply freely to the anoderm as often as necessary, usually 2 to 4 times a day.

Full information available on request.

Warner Chilcott

Division,
Warner-Lambert Company
Morris Plains,
New Jersey 07950

THE PROFESSIONAL SOURCE OF

COMFORT

FOR INTERNAL & EXTERNAL ANORECTAL CONDITIONS



Anusol-HC®

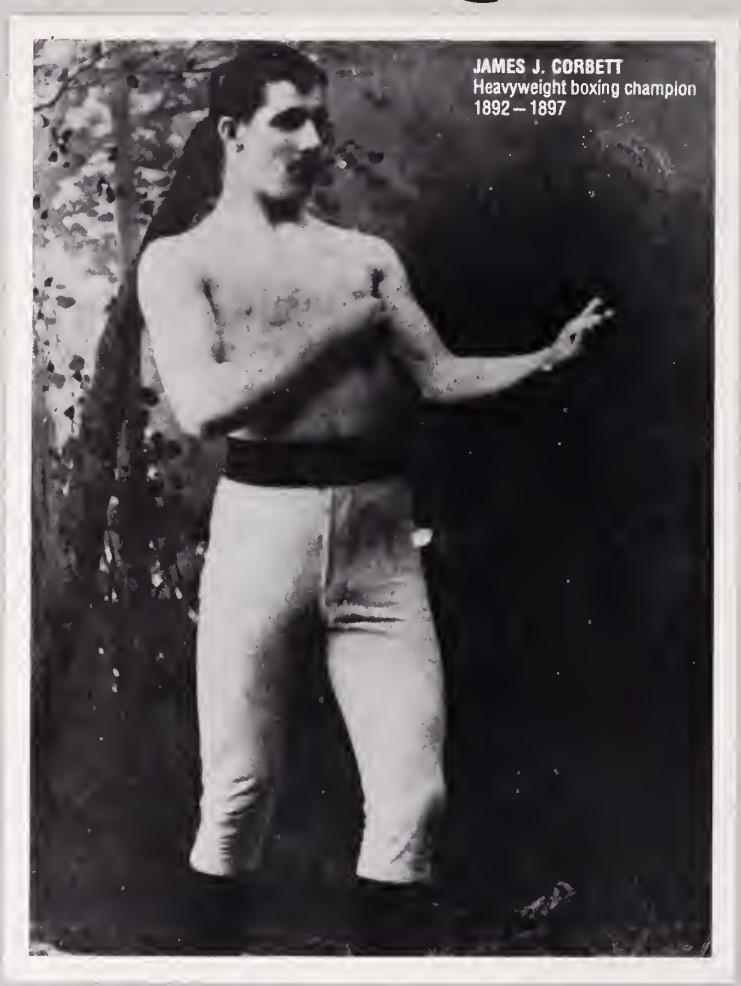
suppositories and cream
with hydrocortisone acetate. Rx only

pain and burning
respond in minutes

• without belladonna alkaloids • without CNS stimulants

Artist's interpretation in bas-relief of external hemorrhoids, postoperative anorectal wounds and anal dermatitis.

Famous Fighters



NEOSPORIN® Ointment
(polymyxin B-bacitracin-neomycin)
is a famous fighter, too.

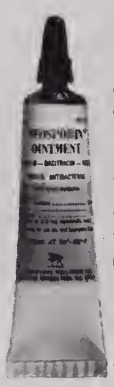
Provides overlapping, broad-spectrum antibacterial action to help combat infection caused by common susceptible pathogens (including staph and strep).

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Immunology Congress Set for Las Vegas

The "Three Faces of Immunology," a new look at allergy today and where it is headed in the next 10 years, is the highlight of the 32nd annual congress of the American College of Allergists at the Las Vegas Hilton April 3-8.

The three "faces"—1) Classical Allergy and Related Disorders, 2) Immunopathology, and 3) Immune Competences and Immunogenics—headline a unique subject-a-day agenda along with the daily topics, "Allergy and the Respiratory Tract," "Ears, Nose and Throat," and "Dermatology."

Registration fees are $35 for college members, interns and residents; $100 for non-members.

For information and registration, contact: American College of Allergists, 2141 Fourteenth Street, Boulder, CO 80302.

Internists Meet in South Carolina

Specialists in internal medicine and related medical fields will hold a three-day scientific meeting on Mar. 5-7, 1976, at the Myrtle Beach Hilton in Myrtle Beach, SC.

Physicians who attend the regional meeting are eligible for credit toward the American Medical Association Physicians' Recognition Award in Category 1.

Aspen Radiology Conference Scheduled

The sixth annual Aspen Radiology Conference will be held March 1-5 at the Aspen Institute for Humanistic Studies, Aspen, Colorado. The conference is designed for physicians and scientists interested in diagnostic radiology, nuclear medicine and radiation therapy and will explore the impact of clinical and technological advances on radiologic practice.

Further information may be obtained from Dr. Emanuel Salzman, Conference Chairman, Division of Radiology, Beth Israel Hospital, Denver, CO 80204.

helping you change things for the better

Canton Exchange Bank

A FULL SERVICE BANK

"Your Account Handled in Strict Confidence"

Each depositor insured to $40,000

Branch Offices

Canton East Branch
Bank Of Madison
Bank Of Ridgeland

FDIC

"Our 95th Year Of Continuous Service"

Federal Deposit Insurance Corporation

A GOOD IDEA



...THAT KEEPS GETTING BETTER.

The Blue Cross & Blue Shield Plan is based on service—both to the public and to the profession.

The Plan's payment method is convenient for subscribers, and it also gives doctors and other providers solid assurance of payment. Through its direct claims payment system, Blue Cross & Blue Shield coverage saves a lot of paper and a lot of time for a lot of people.

It's one of the best ideas yet. And it keeps getting better.

Working together, we can help contain the rising cost of health care.

Blue Cross®
Blue Shield®
of Mississippi

P. O. Box 1043/530 E. Woodrow Wilson Ave.
Jackson, Mississippi 39205 Tel. 982-0010

® Registered Marks Blue Cross Association
℠ Registered Service Marks of the National Association of Blue Shield Plans

DATELINE

Sheen Award Seeks Applicants

Chicago, IL - Nominations for the 9th annual Sheen Award opened Jan. 1. The Dr. Rodman E. Sheen and Thomas G. Sheen Award is presented at the AMA House of Delegates during the annual convention to a physician who has made an outstanding scientific contribution to medicine. The $10,000 cash award and commemorative plaque are made possible through a bequest in the will of the late Thomas G. Sheen. Nominations should be mailed to AMA before Feb. 15.

Community Outreach Produces Benefits

San Jose, CA - A class for drinking drivers operated by an alcoholism treatment center here has produced unexpected benefits to the community in the form of outreach. Nearly one-fourth of those referred to the class by the courts after being charged with drunken driving have brought friends or relatives into the East Valley Alcohol Services Center for treatment of alcohol problems. The program consists of six alcohol awareness instruction sessions.

Whitfield Drug Admissions are Younger

Whitfield, MS - Preliminary results from a recent analysis of drug-related, "first-time" admissions to the Mississippi State Hospital between 1962-74 show a dramatic change in the number of younger patients (under 25) being admitted for drug problems. The data analysis, conducted by the Division of Drug Misuse, looked at more than 2100 admissions. Admissions data suggested an epidemic of drug misuse-related commitments spread among a new, younger population from more widely disbursed areas.

Heart Attack Deaths Will Increase

Baltimore, MD - Deaths from heart attacks will increase 15 to 25% in the next three years as a result of the ongoing recession, predicts M. Harvey Brenner, associate professor of hygiene and public health, Johns Hopkins University. A major study of the link between health and economic downturns has verified the belief that people do get sicker when their financial outlook is imperiled. He predicted a 30-35% increase in alcoholism and a 15-100% increase in mental disorders.

Early Warning of Drug Interactions

Princeton, NJ - An "early warning system" against potential drug interactions is MEDISC ™, a small rotary slide rule that depicts drug interactions among 77 common drugs or categories of drugs. Combinations that can be dialed cover many of those occurring most frequently in modern clinical practice. The pocket-size device is intended as a ready and simple first reference for physicians, nurses, pharmacists, dentists and other health care professionals and distributed by Excerpta Medical Services.



LUFYLLIN® (dyphylline)

Before prescribing, please review complete product information, a summary of which follows:

Indications: For relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

Precautions: Exercise caution with use in the presence of severe cardiac disease, renal or hepatic malfunction, glaucoma, hyperthyroidism, peptic ulcer, and concomitant use of other xanthine-containing formulations or other CNS stimulating drugs.

Adverse Reactions: May cause nausea, headache, cardiac palpitation and CNS stimulation. Postprandial administration may help to avoid gastric discomfort.

How Supplied:

LUFYLLIN, 200 mg., Tablets: NDC 19-R521-92 bottle of 100; NDC 19-R521-97, bottle of 1000.

LUFYLLIN Elixir: NDC 19-R515-68, pint bottle; NDC 19-R515-69, gallon bottle.

LUFYLLIN Injection: NDC 19-R537-T2, box of 25 x 2 ml ampuls.

For relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

LUFYLLIN®
(dyphylline)

...a basic need for the bronchospastic patient.

Tablets: 200 mg dyphylline
Elixir: per 15 ml: dyphylline 100 mg, alcohol 20% v/v

the bronchodilator with a difference...dyphylline.

A NEED FOR YOUR PATIENT BECAUSE . . . . .

1. Therapeutically effective
2. Little to no CNS stimulation
3. Little to no gastric upset
4. Effective during long-term therapy
5. Only 1/5 the toxicity of theophylline or aminophylline[1,2,3] (based on animal studies)

REFERENCES

1. McColl, J. D., et al.: **J. Pharm. & Exp. Therap.** 116:343, 1956
2. Quevauviller, Par Andre, et al : **Presse Med.** 61:1480-1482, 1953
3. Maney, P. V., et al : **J. Am. Pharm. Assoc.** 35:266-272, 1946

Mallinckrodt® Pharmaceuticals *Linking Chemistry to Medicine®*

Mallinckrodt, Inc.
Mallinckrodt Pharmaceutical Division
St. Louis, Missouri 63147

Counsel to Authors

THE JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, Miss. 39216, in original and at least one duplicate copy. They must be typewritten double spaced on 8½ by 11-inch white bond paper with a standard typewriter.

The author is responsible for all statements made in his work, including changes made by the manuscript editor. Manuscripts are received with the understanding that they are not under simultaneous consideration by any other publication and have not been previously published. All manuscripts will be acknowledged, and while those rejected are generally returned to the author, the JOURNAL is not responsible in event of loss. Manuscripts accepted for publication become the property of the JOURNAL and are copyrighted by the association when published. They may not be published elsewhere without written release and permission from both the JOURNAL and the author.

All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10, but when justified to the Editors, additional references will be considered for publication. Each will be critically examined, and only valid, primary references will be published. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus,* volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made after proof sheets are received by the JOURNAL.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for illustration engravings not exceeding four column inches per printed page.

Illustrations must be numbered and cited in the text. Legends, not exceeding 40 words and preferably shorter, must accompany each illustration, typed double spaced on separate sheets. The following information should appear on a gummed label affixed to the back of each illustration: Figure number, manuscript title, author's name, and arrow indicating top of the illustration.

In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

A thesis summary of 75 to 100 words must accompany each manuscript separately from the text.

Reprints may be obtained at cost plus shipping charges from the association and should be ordered prior to publication. The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. —*The Editors.*

Cooley's Anemia Studied at Medical Center

Scientists at the University of Mississippi Medical Center are participating in a nationwide study to make the treatment for Cooley's anemia a real eure.

A $120,000 three-year contraet from the National Institutes of Health will allow Dr. Rowe Byers, professor of microbiology, and his researeh team to isolate and prepare eompounds from mieroorganisms whieh ean remove exeess iron the body aeeumulates from Cooley's anemia treatments.

"The treatment for this severe form of thalassemia —frequent blood transfusions—is the main eause of iron overload," explained Dr. Byers. "Over the years, the body aeeumulates so mueh iron it ean't get rid of it all. Too mueh iron is poisonous and can eause early death for many Cooley's anemia patients."

Prior to the nationwide study, the UMC investigators had isolated one sueh eompound. NIH awarded the team a eontraet to develop 13 more whieh will be tested in laboratory animals at the Mason Researeh Corporation in Woreester, Mass.

One has already proved effeetive and harmless in miee, and seientists hope that humans will soon benefit from it.

Using yeast, fungi, and bacteria, the UMC scientists isolate the eompounds eapable of binding with iron. The iron, if eombined wtih the binding agent, ean be passed from the body instead of being stored in lethal amounts.

About two dozen other compounds have been developed in other researeh eenters around the world.

"In years to eome," Dr. Byers said, "seientists may diseover a eure for Cooley's anemia through genetic research. But now, the most praetical and simple solution is to find a way to stop the iron buildup."

Gastroenterologists Plan Meeting

A regional meeting of the American College of Gastroenterology will be held at The Grand Hotel in Point Clear, AL, on Feb. 14 and 15, 1976.

The program will eonsist of a one and a half day session made up of individual papers as well as a panel discussion on "Retrograde Cannulation."

Further information may be obtained from American College of Gastroenterology, 299 Broadway, New York, NY 10007.

Hill Crest
HOSPITAL
Hill Crest Foundation, Inc.

A non-governmental psychiatric hospital. Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved.
Phone: 205-836-7201



A short-term, intensive treatment center for psychiatric disorders, alcoholism, and drug abuse.

MEDICAL DIRECTOR:
James K. Ward, M.D.

Member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Birmingham Regional Hospital Council.

6869 Fifth Avenue South
Birmingham, Alabama 35212

Surgical Forum III Set for March in Jackson

Surgeons from at least 27 states and Puerto Rico will come to Jackson Mar. 11-13 for the University of Mississippi Medical Center Postgraduate Surgical Forum III.

Twelve internationally known surgeons will join UMC faculty for the three-day program at Holiday Inn Downtown.

Participants will hear lectures and panel discussions on vascular, general, stomach, and biliary tract surgery. Early registrations range from California to Maine, from South Dakota to Florida.

The University of Mississippi School of Medicine Department of Surgery and University Medical Center Division of Continuing Health Professional Education sponsor the annual event. Attendance is by invitation, and advance registration is required.

Conference coordinators are Dr. James D. Hardy, UMC professor of surgery and chairman of the department, and Dr. William O. Barnett, professor of surgery.

Guest faculty are Dr. Curtis P. Artz, Medical University of South Carolina, Charleston; Dr. John M. Braasch, Lahey Clinic Foundation, Boston; Professor J. C. Goligher, The General Infirmary, Leeds, England; Dr. George L. Jordan, Jr., Baylor College of Medicine, Texas Medical Center, Houston; Dr. Lloyd M. Nyhus, University of Illinois Medical Center, Chicago; Dr. Marshall J. Orloff, University of California, San Diego; Dr. William H. ReMine, Mayo Medical School, Rochester, MN; Dr. Charles G. Rob, University of Rochester School of Medicine, Rochester, NY; Dr. David C. Sabiston, Jr., Duke University Medical Center, Durham; Dr. John L. Sawyers, Vanderbilt University, Nashville; Dr. James C. Thompson, University of Texas Medical Branch, Galveston; and Dr. Robert Zeppa, University of Miami School of Medicine, Miami.

Mississippi medical school faculty who are on program are Dr. Hardy; Dr. Barnett; Dr. J. Harold Conn, professor of surgery; Dr. Joseph C. Gabel, associate professor of anesthesiology; Dr. J. Harvey Johnston, Jr., clinical professor of surgery; Dr. Martin H. McMullan, clinical instructor in surgery; Dr. Richard C. Miller, professor of surgery; Dr. Norman C. Nelson, vice chancellor and professor of surgery; and Dr. W. Coupery Shands, clinical associate professor of surgery.

Is there a tablet containing *only* an expectorant and *only* Glyceryl Guaiacolate? YES!

1. Patient acceptable tablet dose.
2. Single entity expectorant.
3. Measured tablet dose.
4. Sugar-free tablet.

An identifiable white, scored tablet which significantly stimulates the secretion of respiratory tract fluid.

HYTUSS TABS

(GLYCERYL GUAIACOLATE 100mg.)





Composition: Each sugar-free compressed tablet contains glyceryl guaiacolate 100mg. **Action and Use:** This preparation utilizes the effective expectorant action of glyceryl guaiacolate which significantly stimulates the secretion of respiratory tract fluid. The increased flow of less viscid fluid favors expectoration and has a demulcent effect on the tracheobronchial mucosa. The primary usefulness of Hytuss Tabs is to promote the change from a dry, unproductive cough to a productive cough. Hytuss is therefore useful in treating coughs due to the common cold, bronchitis, laryngitis, tracheitis, pharyngitis, influenza and the measles. The expectorant action of Hytuss may also provide symptomatic relief in some chronic respiratory disorders when the patient experiences spasms of dry nonproductive coughing. **Precautions:** Extremely large amounts may cause nausea and vomiting. **Administration and Dosage:** *Adults*—1 tablet four times daily. *Children*—6 to 12 years of age; ½ tablet 3 or 4 times daily. HOW SUPPLIED: White, scored, sugar-free, tablet in bottles of 100 - 1,000 - 5,000. **Product Identification Mark:** Hy. **Literature Available:** On request.

Available through all drug wholesalers.

Hyrex

HYREX COMPANY

832 South Cooper
Memphis, Tenn. 38104

11th Annual ASCMS Assembly Set

Drs. Michael DeBakey, Eliot Corday, John Laragh, R. Lee Clark, George Crile, Jr., Louis Weinstein and Owen Wangensteen will head a faculty of nearly 100 leaders of American medicine at the 1976 American Society of Contemporary Medicine and Surgery Scientific Assembly, Feb. 29-Mar. 5, Americana Hotel, Bal Harbour, FL.

Seminars include cancer, cardiovascular disease, hypertension, alimentation, infectious disease, gastroenterology, pulmonary disease and special medicine and special surgery. CME Accreditation is 40 hours Category 1, AMA; 30 elective hours, AAFP.

For information and program write Dr. John Bellows, ASCMS Director, 30 North Michigan Avenue, Chicago, IL 60602.

Adolescent Care Unit

350 Crossgates Blvd.
P. O. Box 738
Brandon, Mississippi 39042
(601) 982-8151

A private, in-patient intensive psychiatric treatment unit for a wide range of nervous, emotional, mental and personality disorders. Accredited and Licensed. Academic programs maintained by Educational Psychologist. The Adolescent Care Unit is situated in a General hospital less than two miles from the Jackson Municipal Airport.

C. Mims Edwards, M.D.,
Attending Psychiatrist
Barbara Goff, M.D.,
Consulting Psychiatrist

Have You Made Your Reservations?

MISSISSIPPI STATE MEDICAL ASSOCIATION

108th ANNUAL SESSION

May 3-6, 1976
Holiday Inn Downtown
Jackson, Miss.

Excellent Scientific Program
Scientific and Technical Exhibits
Fellowship and Fun

HOW MUCH DO YOU MAKE?

That's how much you could lose . . . and more . . . if an accident or illness totally disabled you and you were unable to continue your practice. Not only would you lose your personal income, but the cost of maintaining your office would also continue. YOU COULD LOSE TWICE AS MUCH as another person might because you have two sets of expenses. To help you fight this possibility, the Mississippi State Medical Association makes available to members two excellent programs that help cover both ends of your expense picture: the INCOME PROTECTION PROGRAM for personal expenses, and the tax-deductible PROFESSIONAL OVERHEAD EXPENSE PROTECTION PROGRAM for your business expenses.

■ TO HELP PAY YOUR PERSONAL EXPENSES, THERE'S MSMA'S INCOME PROTECTION PROGRAM

When you're not practicing, your income stops. Just paying your everyday expenses could run into a great deal of money, draining your savings, especially if your income were cut off indefinitely. The MSMA INCOME PROTECTION PROGRAM can pay as much as $2,000 a month income replacement benefits payable for up to LIFETIME for accident-caused disabilities, TO AGE 65 for disabilities resulting from illness. And, you choose when you want the benefits to begin — either the 31st or the 91st day of disability — to give you the coverage that best fits your own individual needs.

■ TO HELP PAY BUSINESS COSTS, PROFESSIONAL OVERHEAD EXPENSE PROTECTION'S FOR YOU

Whether you're there or not, it costs the same amount of money each month to keep your office open. But, with no money coming in, it could really put you in a serious financial position. You need the businessman's insurance with your practice in mind — the MSMA PROFESSIONAL OVERHEAD EXPENSE PROTECTION PROGRAM. It works for you when you can't. It'll pay 100% of your covered fixed overhead costs — even up to $3,500 a month, the maximum amount available. And, the benefits are available for as long as 18 months. Premiums may be deducted as a direct business expense, too.

WANT TO KNOW MORE? WRITE TODAY!

Protect yourself and your family. Protect your investment in your business. Find out more about these exceptional MSMA Programs. Write to THOMAS YATES & CO., P. O. Box 1054, Bankers Trust Plaza Building, Jackson, Mississippi 39205 for brochures describing the benefits, features, limitations, exclusions and premiums of each Plan.

These Plans Are Offered By

THOMAS YATES & CO.
P.O. Box 1054
Bankers Trust Plaza Building
Jackson, Mississippi 39205

THOMAS YATES & CO. has been awarded the seal of the American Institute of Professional Association Group Insurance Administrators — "In recognition of professional excellence in serving clients with an integrity worthy of the highest trust." Membership in the Institute is by invitation only.

THESE PLANS ARE MSMA SPONSORED

The INCOME PROTECTION PROGRAM and the PROFESSIONAL OVERHEAD EXPENSE PROTECTION PROGRAM are officially sponsored and endorsed by the Mississippi State Medical Association exclusively for its members.

Also sponsored by the MSMA are the HOSPITAL MONEY PLAN, MAJOR MEDICAL PLAN, EXCESS MAJOR MEDICAL PLAN, and TERM LIFE INSURANCE. Brochures for these programs are also available.

Underwritten By

CONTINENTAL CASUALTY Co.
Association Group Division
CNA Plaza • Chicago, Illinois 60685

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
February 1976, Vol. XVII, No. 2

ORIGINAL PAPERS

Modern Temporal Bone Surgery—Finding the Key

GALE GARDNER, M.D.
Memphis, Tennessee

The author maintains that the key to understanding the newer surgical procedures for temporal bone disease is basic understanding of the structure, function and method of examination of the temporal bone. He discusses these topics along with Meniere's disease, acoustic tumors, facial nerve disorders, unilateral labyrinthine dysfunction, and lesions and deformities of the middle ear and ear canal.

Otology has developed during the past 20 years from a specialty primarily oriented to the treatment of infection and its complications to one much more involved with the preservation and restoration of normal hearing, balance, and facial nerve function. This has led to an improvement in overall surgical care, but has made it difficult for physicians both in and out of otolaryngology to keep up with the newer procedures that have been developed and make them available to their patients.

The key to understanding modern temporal bone surgery is a basic understanding of the structure, function, and method of examination of the ear. The purpose of this paper is (1) to help in this understanding, and (2) to describe some of the current concepts of otologic surgical treatment, based on such an understanding.

The ear consists of two very delicate neural end organs, one for hearing, the cochlea; and the other for balance, the semicircular canals and vestibule. These membranous structures are filled with inner ear fluid, are located within the temporal bone, and are connected centrally to the brain stem by the cochlear and vestibular divisions of the eighth cranial nerve. The hearing portion of this system is connected to the outside by way of the ear canal, the typmpanic membrane, and the chain of three small hearing bones or ossicles. The ossicles span the middle ear space, the first being attached to the ear drum and the third attached to the inner ear. The middle ear space is connected to the nose by the Eustachian tube anteriorly, and to the mastoid air space posteriorly. The facial nerve crosses the temporal bone from the internal auditory canal medially to its exit at the base of the mastoid tip.

Sound vibrations enter the ear canal, and travel through the eardrum, the three ossicles, and the inner ear fluid system. The sound energy is then converted to electrical energy and transmitted to the brain stem over the hearing nerve.

Head motion causes movement of this same fluid system, which is also converted into electrical energy and transmitted to the brain stem as balance signals over the vestibular nerve.

The Eustachian tube allows maintenance of equalized air pressure on both sides of the eardrum, which in turn allows free motion of the three os-

From the Department of Otolaryngology and Maxillofacial Surgery, University of Tennessee, Center for the Health Sciences, Memphis, Tenn.
Presented before the Section on EENT, Mississippi State Medical Association, Bilioxi, May 6, 1975.

sicles within the middle ear space. Blockage of the Eustachian tube produces a vacuum within the middle ear and results in impaired motion of the ossicles and in turn, a hearing loss.

The use of the operating microscope is basic to modern temporal bone surgery and has revolutionized the diagnosis of tympanic membrane and middle ear disorders.

Audiometry is the testing of hearing function and is basic to evaluation of the ear. It involves presenting sound signals of known intensity to a patient who is in a sound-treated booth, to establish the level of hearing. Hearing losses as well as specific types of losses can thus be diagnosed. Failure of sound to reach the inner ear due to some problem with the conductive system (ear canal, eardrum, or ossicles) is called a conductive hearing loss and differs audiometrically from a hearing loss due to a problem involving the cochlea or nerve of hearing, which is called a sensorineural hearing loss. Tuning forks are also helpful in making this differentiation. More sophisticated hearing tests allow differentiation between a sensorineural hearing loss due to a problem within the cochlea, or due to a problem in the nerve of hearing (retrocochlear).

ENG, or electronystagmography, is a method of recording eye movements, which are under the control of the inner ear balance centers, and thereby indirectly studying the function of the balance centers. Electrodes are placed around the eyes, and the electrical potentials from the eye are picked up in much the same way that cardiac potentials are picked up by EKG electrodes.

Temporal bone radiography, using plane films, sophisticated laminographic equipment such as the Polytome, or the use of contrast material within the posterior fossa are extremely important in the diagnosis of temporal bone tumors.

Temporal bone disorders and their surgical treatment can be best understood by grouping the various disorders around the basic structure and function of the ear. Therefore we can think of disorders of the inner ear, facial nerve, ear canal, Eustachian tube, and middle ear.

INNER EAR

Inner ear disorders are probably the most difficult ear problems to become familiar with. Inner ear structure and function is usually more obscure to the physician, and it is an area that is considered to be somewhat isolated from effective medical and surgical treatment. But times are changing, and we must begin to make the effort to look at these conditions more aggressively if the patient is to have the most effective medical and surgical treatment reasonably possible.

Meniere's Disease. Meniere's disease should not be used as a waste basket term for all types of inner ear disorders. Rather it is a specific condition in which there is an increased amount of inner ear fluid, or endolymph, which produces distention and distortion of the membranous structures of the inner ear. It produces a distinct type of sensorineural hearing loss, usually in only one ear, tinnitus, and attacks of spontaneous vertigo. It can be exceptionally disabling, but is also subject to sudden spontaneous remissions with relief of symptoms.

The great majority of patients recover spontaneously in this way, or with the help of medical treatment. A distinct small minority of patients, however, are not so fortunate. These patients sustain additional sensorineural hearing loss with each attack, and over a period of several years may lose most of their effective hearing in the involved ear. Surgical treatment for these patients is now available.

In its early stages, before the hearing loss becomes extensive, but when the attacks of vertigo are disabling, the aim of treatment is to eliminate the attacks of vertigo, to stabilize, and perhaps even improve the hearing. The endolymphatic sac shunt operation is designed to accomplish this.[1] This procedure is performed through a post-auricular incision and through the mastoid space. The endolymphatic sac is an extension of the inner ear membranous endolymphatic system and can be approached and opened in the mastoid without disrupting the more central inner ear structures. Having opened the space, the problem is to drain away the over-accumulation of inner ear fluid permanently. Fortunately the subarachnoid space lies immediately beneath the sac. One can open the sac from the outside, then make an opening in the inner wall of the sac and place a small permanent shunt tube from the interior of the sac into the underlying subarachnoid space. Excess endolymph is released into the subarachnoid space.

This procedure is used only in patients who are considered medical failures. In my own series of 31 patients, it has been successful in relieving vertigo and stabilizing hearing in 65 per cent of cases. Hearing has actually been improved in 32 per cent.

When conservative surgery is not successful, or when the patient's hearing is so severely impaired that it is not worthwhile trying to save hearing, destruction of the inner ear is preferable. This allows

relief of vertigo in as high as 99 per cent of cases, depending on the method of destruction used. Although a number of approaches for destroying the function of the ear are available, I prefer to accomplish as complete a destruction as possible in order to allow the least chance of later recovery of function and recurrence of symptoms. For this reason I use a trans-mastoid labyrinthectomy with sectioning of the vesibular and cochlear nerves. This operation is performed through a post-auricular incision and through the mastoid space. It involves use of the operating microscope and high-speed surgical drill so as to open the inner ear spaces and remove their membranous contents, and then to locate the vestibular and cochlear nerves in the internal auditory canal. These nerves are indivdiually sectioned, with careful preservation of the adjacent facial nerve.

It is important that patients with Meniere's disease who do not recover spontaneously and who continue to experience disabling vertigo be recognized so that they can be offered the benefit of surgical treatment.

Acoustic Tumor. The most significant lesion involving the inner ear is the acoustic neuroma. This develops on the eighth cranial nerve, usually inside the internal auditory canal, then grows medially into the cerebellopontine angle. In the past this tumor has not been diagnosed until it reached a size sufficent to produce unmistakable intracranial signs and symptoms. The morbidity and mortality resulting from late treatment at this stage were formidable.

It is now possible to diagnose this tumor much earlier, when it is smaller and can be removed with greater safety and less neurologic complications. Such early diagnosis is based on recognition of the alerting symptoms of unexplained dizziness and progressive unilateral hearing loss and tinnitus, and by the use of audiometry, ENG, and radiography for confirmation.

The operating microscope, high-speed drill, and surgical knowledge of the temporal bone allow the otologist to contribute to the removal of these tumors by working as a team with the neurosurgeon. Such a team approach has been particularly helpful in facial nerve preservation during tumor removal.

Although great advances have been made in the diagnosis and treatment of this tumor, the main contribution yet to be made is early recognition at the primary care level of the alerting symptoms of unexplained dizziness, progressive unilateral hearing loss, and tinnitus.

Unilateral Labyrinthine Dysfunction. Patients who have had head injuries, with or without basilar skull fracture and with subsequent dizziness may have definite unilateral labyrinthine dysfunction as a result of labyrinthine concussion or fracture. Usually these patients recover spontaneously or with medical treatment. When they do not, and when the dizziness is disabling, additional workup is indicated. If serial ENGs show consistent and definite dysfunction of one labyrinth, surgical treatment is indicated in order to relieve the balance disorder. If hearing is undamaged, the vestibular nerve can be sectioned by approaching the internal auditory canal from above. If hearing has been lost as a result of the injury, a labyrinthectomy with sectioning of the vestibular nerve, as described for far-advanced Meniere's disease, is the treatment of choice.

FACIAL NERVE

The facial nerve is usually thought of as being within the province of neurology or neurosurgery, even though its course lies largely within the temporal bone and even though nine out of ten lesions involving the nerve occur within the temporal bone. Use of the operating microscope and highspeed drill have opened the entire temporal bone to the otologic surgeon, and otolaryngology now has a significant role to play in the diagnosis and treatment of disorders of the facial nerve.

Conditions which may affect the facial nerve within the temporal bone are Bell's palsy, tumors, and trauma. It is comforting for physicians treating a case of Bell's palsy to realize that approximately 90 per cent of cases recover spontaneously, and that the use of steroids appears to make this even more certain.[2] Primary tumors of the facial nerve, usually neuromas, have been considered to be so rare as hardly to deserve attention. Temporal bone trauma, usually resulting from basilar skull fracture, was frequently considered something for which nothing practical could be done except perhaps for a fascial sling procedure, or perhaps a by-pass nerve graft using the eleventh or twelfth cranial nerves. As is true in so many things, times are changing, and along with them ideas regarding management of these facial nerve lesions.

Bell's Palsy. In every large series of patients having Bell's palsy, a small percentage of patients are left with a poorly functioning face and a resulting serious cosmetic problem. The impact of this on the patient is heavy indeed. Two facts make it possible for us to reduce the incidence of these unfortunate results. First, permanent impairment of function of the nerve implies that actual degeneration of the

nerve occurred at some point in time in a small percentage of cases. Electrical testing can identify this occurrence fairly promptly and with reasonable accuracy. Second, prompt surgical decompression of the nerve within the temporal bone, by opening the nerve canal and incising the nerve sheath, releases the pressure on the usually edematous nerve and appears to allow recovery to occur. This surgical treatment is required, however, in only a very small percentage of patients with Bell's palsy.

The fact that poor results can occur, yet could be prevented by prompt recognition and surgical intervention, makes it important that we be alert to recognize this unusual situation.

Facial Nerve Neuromas. The late Sir Terrence Cawthorne, English otologist, observed that "all that palsies is not Bell's." The physician who treats Bell's palsy must be aware of this, or he will overlook the case of apparent Bell's that is actually due to a neuroma of the nerve, usually within the temporal bone. Recurrent episodes of paralysis with intervening apparent good recovery should alert the physician to be suspicious of this. X-rays allow the diagnosis to be made, and temporal bone surgery allows tumor removal with placement of a nerve graft. Otherwise this tumor produces widespread destruction to other temporal bone structures.

Facial Nerve Injury. Basilar skull fractures and other injuries to the temporal bone frequently produce facial nerve injury. Usually there is simultaneous injury to the hearing and balance structures as well. The otolaryngologist is in a particularly good position to diagnose the site of injury to the nerve, the necessary diagnostic tests being a part of his routine workup. The operating microscope and high-speed drill allow him to approach the site of injury, evaluate the extent of the injury, and either approximate the severed nerve endings or place a nerve graft when this is necessary. Results with this type of treatment are much superior to acceptance of non-function, or to plastic procedures on the facial musculature.

EAR CANAL

Congenital meatal atresia and carcinoma are two very significant surgical conditions that affect the ear canal.

Congenital Atresia. Congenital Atresia of the ear canal may or may not be associated with abnormalities of the auricle and middle ear structures. In the past, emphasis has been placed on cosmetic correction of the external ear deformity when it was present. Now, using the techniques of tympanoplasty, a new ear canal and eardrum can usually be created and the middle ear structures repositioned so that sound energy can be delivered to the inner ear. This is particularly important in bilateral cases prior to school age in order to provide necessary hearing. Equally important is the necessity to fit the child with a hearing aid prior to surgery, during the years in which speech is developed. In unilateral situations with normal hearing in the uninvolved ear, corrective surgery for hearing is not nearly as critical.

Carcinoma. Any apparent external infection of the ear which does not clear, and particularly when associated with severe pain, should raise the question of possible carcinoma. Newer surgical procedures for the treatment of this malignancy have lowered the previously very high mortality rate.

EUSTACHIAN TUBE

Eustachian tube dysfunction produces three major types of problems, acute otitis media, serous otitis media, and chronic otitis media with perforation of the tympanic membrane. The problem of acute otitis media is well understood, and no significant changes have occurred in its treatment. Rarely, it is associated with acute mastoiditis in children, which may require surgery.

Serous Otitis Media. Serous otitis media is an accumulation of transudate within the middle ear space, usually with retraction of the tympanic membrane and a conductive hearing loss, and occurring predominantly in younger children. There are several approaches to treatment. Some prefer to do a thorough adenoidectomy, which many times solves the problem. Others prefer the placement of pressure equalizing tubes through the tympanic membrane. Still others believe that the disease is on an allergic basis and prefer allergic management as the primary form of therapy. No one of these approaches solves all of the problems, which can be extremely frustrating at times to all concerned. Generally speaking, however, hearing loss can be corrected most of the time and the problem controlled. The primary contribution of the general physician is early detection of the serous otitis before hearing loss produces a problem with speech development and school work, or a chronic otitis media.

Chronic Otitis Media. Chronic otitis media with perforation of the tympanic membrane is of two types, depending on the location of the perforation. A perforation that does not extend to the bony margins of the drum is called a central perforation,

while a perforation that is not so limited is termed a marginal perforation. The significance of this distinction is that in the marginal perforation skin frequently invades the middle ear space and perhaps the mastoid space as well, producing a special type of problem called a cholesteatoma. In a central perforation this invasion of skin rarely occurs. When a cholesteatoma is present, it is likely to produce complications such as destruction of the ossicles, involvement of the inner ear causing labyrinthitis, and even complications of the central nervous system such as epidural and subdural abscess, meningitis, and brain abscess.

Treatment is nearly always surgical. This type of surgery is termed tympanoplasty, and consists of repair of the perforated drum when feasible, by using mesodermal tissue such as fascia or vein as a graft, along with rearrangement of the ossicles when they have been damaged by the disease. This is all that is usually necessary for a central perforation. In the case of a marginal perforation with cholesteatoma, it is necessary to remove the sac of skin in its entirety, or failing this, to exteriorize the growth of skin in the middle ear by removal of the overlying eardrum. When the skin growth extends into the mastoid, exteriorization, if necessary, requires removal of the bone over the mastoid and the bone that separates the mastoid from the ear canal. This is called a radical mastoidectomy, and produces a mastoid cavity.

Since these cavities are themselves subject to recurrent infections unless they are cleaned regularly, it is desirable to remove the skin growth in its entirety without exteriorization and production of a mastoid cavity. This is called intact canal wall tympanoplasty.

When a cavity is already present and is infected, it may be obliterated with autogenous bone paste and homogeneous femoral head bone chips. This may be combined with a tympanoplasty and constitutes an effort to return the ear as completely as possible to its original pre-diseased state.

MIDDLE EAR

Other middle ear problems not resulting from Eustachian tube dysfunction are otosclerosis and glomus tumors.

Otosclerosis. Otosclerosis, more properly called otospongiosis, is a growth of new, imperfect bone, usually adjacent to the third ear bone or stapes, which limits the motion of the stapes against the inner ear and produces a conductive hearing loss. The present treatment does not differ greatly from the original surgical procedure developed by John Shea 20 years ago in which he replaced the stapes with a prosthesis, which was fitted between the second ear bone (incus) and the opening into the inner ear. At present, a number of prostheses are available for replacement of the stapes. Usually a vein or fascial graft is placed between the prosthesis and the inner ear. Hearing is restored to near normal levels in approximately eight or nine cases out of ten. Diagnosis is based on a high index of suspicion in the presence of an unexplained conductive hearing loss with a normal-appearing tympanic membrane. Otosclerosis may apparently also involve the bone covering the inner ear and produce a sensorineural (nerve) hearing loss.

Glomus Tumor. A glomus tumor is a benign growth that may arise from either the middle ear or from the dome of the jugular bulb at the base of the skull. It arises from neural tissue in these locations. The latter type is referred to as a glomus jugulare tumor, and tends to extend into the middle ear. Treatment is surgical removal. Diagnosis is based on recognition of a reddish mass behind the tympanic membrane, sometimes pulsating, and nearly always producing a pulsing tinnitus.

SUMMARY

The key to understanding the newer surgical procedures for temporal bone disease is basic understanding of the structure, function, and method of examination of the temporal bone.

Surgery may be extremely helpful in the treatment of Meniere's disease, either early while hearing is still good, or later after useful hearing has been lost.

In order to utilize the newer surgical techniques for the removal of acoustic tumors, an early diagnosis must be made. This requires that the primary care physician recognize the early alerting symptoms of this important lesion.

Surgery is also helpful in disorders of facial nerve, unilateral labyrinthine dysfunction, and lesions and deformities of the middle ear and ear canal. ★★★

899 Madison—602A (38103)

REFERENCES

1. Gardner, Gale: Endolymphatic Sac Shunt Operation in Meniere's Disease. Transactions of the American Academy of Ophthalmology and Otolaryngology. In press.
2. Adour, K. K., Wingerd, J., Bell, D. N., Manning, J. J. and Hurley, J. P.: Prednisone Treatment for Idiopathic Facial Paralysis (Bell's Palsy). New England J. Med., 287:1268-1272, 1972.

A Review of Management of Patients With Urinary Stones at the North Mississippi Medical Center

JOHN P. ELLIOTT, JR., M.D., JAMES O. GORDON, M.D.,
JOHN W. EVANS, M.D., and LUCAS PLATT, M.D.
Tupelo, Mississippi

In 1973, 361 patients with urinary stones were admitted to the North Mississippi Medical Center. In 212 of the patients the stones passed spontaneously.

An intravenous pyelogram is obtained the day following admission of a patient with a urinary stone and a decision made at the time regarding surgical or attempted medical management. Ordinarily, a culture of the urine is obtained the day of admission and appropriate antibiotic therapy is instituted. Varidase is given to aid in the reduction of edema surrounding the stone in the ureter. We frequently will augment the passage of small calculi by osmotic diuresis wtih 4 per cent urea or 5 per cent Mannitol. We occasionally place indwelling ureteral catheters for dilation of the ureter. For obstreperous stones in the lower one-third of the ureter and less than 5 to 7 mm. in diameter, we will make an attempt at stone manipulation by Dormia stone basket. Open surgical procedures are utilized in those patients for which the stone will obviously not pass or is presenting complications. A serum calcium is obtained on admission, but if it is found to be elevated, no further calcium tests are done until the kidney is relieved of its obstruction by the stone.

Once the stone is obtained, it is sent for analysis (radiographic analysis or crystallographic analysis is preferred over chemical analysis). Because there is reported as high as a 70 per cent chance of recurrence during a lifetime for the patient who has passed his first stone, further observations are made in relation to the prevention of subsequent stones.[3]

The history of the following is pertinent:[1] surgical diversion of the urinary tract with urinary infection, immobilization from bone fractures (resulting in mobilization of calicum from the bone), intestinal disorders and surgical intestinal bypasses (resulting in increased absorption of oxylates from the intestine), chronic ingestion of large amounts of ascorbic acid (high in oxylate) or acetazoliamide (Diamox), which is said to occasionally cause stones. Beck's sarcoid may cause stones, but the hypercalcemia is usually corrected by corticosteroids. Primary hyperoxaluria is a rare disorder characterized by the urinary excretion of large amounts of oxylates. Renal tubular acidosis is less rare, but may be ruled out in any patient who is able to concentrate any early morning urine specimen to 5.3 pH or less.[6] Hyperparathyroidism is diagnosed primarily by a persistently elevated serum calcium.

The authors review the cases of 361 patients with urinary stones who were admitted to the North Mississippi Medical Center in 1973. They discuss their customary treatment and procedures and describe the different types of stones, giving the formation, prevention and treatment of each.

Other contributing factors to stone disease are occupation, race and sex. Sedentary life seems to increase the chance of stone disease. For instance, in Czechoslovakia, desk workers have 20 times higher incidence of stone disease than farmers.[3] Race and sex also affect stone disease. Blacks have less stone disease than Caucasians. This probably indicates the racial difference in absorption of calcium. Women form only 25 per cent as many uninfected stones as men. They experience more infected stones, however; and when all stones are considered, the frequency is about equal between men and women.

Although the ulcer patient on large quantities of milk and alkali is said to have increased stone pro-

Presented before the Section on Family Practice, Mississippi State Medical Association, Biloxi, May 6, 1975.

pensity, there is no definite evidence that large intake of dairy products alone increases stone formation in man.[1] Milk contains three constitutents that cause urinary calculi: calcium, phosphorus, and lactose (a powerful lithogenic agent).[2] It does seem inappropriate for a patient to take large quantities of a substance that is a known constitutent of most stones.

Genetics also has a influence. If a member of your family forms stones, you are 10 times more likely to form stones than the general population. It is interesting that in Czechoslovakia stones are only half as common in people with blue-green eyes as in people with brown eyes.[2]

Analysis of stones found at the North Mississippi Medical Center is: calcium oxalate, 83 per cent; calcium phosphate with oxylate, 5 per cent; magnesium ammonium phosphate, 9.5 per cent; uric acid, 1.5 per cent; and cystine, 1 per cent.

CALCIUM OXALATE STONES

Calcium oxalate is by far the most common type of stone formed in the United States. Most patients who form a calcium oxalate stone will have an increased amount of calcium and oxalate in the urine. To be avoided in the diet are dairy products (calcium, phosphorus, lactose) and excessive amounts of drinks containing oxalate such as tea, cocoa, cola drinks and fruit juices. All greens, including spinach, mustards and lettuce, contain oxalates.

On review of nearly 800 of our surgical stone cases, we found the incidence of smaller stones lower in winter and spring and higher in summer and fall.[5] Hot weather correlates with this seasonal variation and therefore, underwrites the importance of preventing dehydration in patients who form stones.

An increase in urine output leads to a shorter transit time through the kidney giving less time for crystals to combine. It also spreads the crystals apart, decreasing the likelihood of forming larger particles.[1] Every stone-forming patient should try to obtain a urine output of at least 2 quarts a day. Patients who are very serious in their attempts should obtain a urine output of 4 quarts per day. Very little significant aid can be obtained from hydration beyond this point. During the hot months there are great losses of water through the skin and lungs by breathing. Attention must be directed to the output (rather than the intake) and a 24 hour urine specimen to demonstrate adequate or inadequate volume is frequently indicated. The British Royal Navy decreased its stone incidence by 86 per cent simply by increasing the daily urine output by 50 per cent from 800 ccs. to 1200 ccs.[2]

Some have voiced fears that the type of water may be a contributing factor to stone disease. There is conflicting evidence regarding correlation of high mineral contents of water and stone disease.[4, 7] The evidence for hydration, however, is so overwhelming as to make the type of hydration insignificant.

Therapy in chronic oxalate stone formers serious about reducing the number of stones is as follows: diuretics, phosphates, magnesium oxide and methylene blue.[1] HydroDiuril 50 mgs. b.i.d. is usually our first choice. No salt restriction is prescribed other than taking the salt shaker away from the table and no potassium supplementation is given. If the patient's side effects from hypokalemia are too severe, then 1500 mgs. to 2000 mgs. of phosphate is given in daily divided doses.

MAGNESIUM AMMONIUM PHOSPHATE STONES

Diet has very little to do with the formation of magnesium ammonium phosphate stones.[1] They are always associated with infection. Control of the infection after removal of the stone is the method of therapy. Occasionally, methylene blue in combination with antibiotics is used postoperatively.

CALCIUM PHOSPHATE STONES

Calicum phosphate is usually found in combination with calcium oxalate stones.[1] The same therapy is utilized for calicum phosphate stones as with calcium oxalate. Sometimes a pure calcium phosphate stone is formed in the patient with a constantly alkaline urine and the correction for the stone formation is to correct the alkaline urine.

URIC ACID OR GOUTY STONES

Patients with uric acid or gouty stones will not always have gout. They form stones because they never have an alkaline urine.[1] The normal patient has an alkaline urine after meals in the early morning for a short time (alkaline tides). Alkaline urine dissolves crystals of uric acid. A teaspoon of bicarbonate of soda (baking soda) or citrocarbonate one to three times daily is usually sufficient to prevent formation of uric acid stones. The urine should be checked by Nitrozene paper to see if it is alkaline after the dose of soda. Zyloprim is occasionally used to prevent the formation of uric acid or to treat gout.

CYSTINE STONES

Cystine stone formation is a hereditary disorder.[1] Alkalinization of urine usually prevents these stones. D-Penicillimine is used in occasionally severe cases.

SUMMARY

The clinical management of urinary stones is discussed. The etiology of these stones can have a genetic basis, be drug-induced, occur from urinary tract infections or have other documented causes. For long term management of patients, analysis of the urinary stones will direct the type of medical management combined with a daily water-induced diuresis. ★★★

605 Garfield Street (38801)

REFERENCES

1. Thomas, William C. Jr.: Medical Aspects of Renal Calculous Disease. Urol. Clin. N. Amer., 1:262-276, 1974.
2. Finlayson, B.: Renal Lithiasis in Review. Urol. Clin. N. Amer., 1:204, 1974.
3. Finlayson, B.: Renal Lithiasis in Review. Urol. Clin. N. Amer., 1:182-183, 1974.
4. Kohler, Peter: Asymptomatic Upper Urinary Tract Lithiasis in Flying Personnel. J. Urol., 86:372, 1961.
5. Elliott, J. P., Gordon, J. O., Evans, J. W., Platt, L. O.: A Stone Season, accepted for pub. J. Urol. April, 1975.
6. Smith, L. H.: Medical Evaluation of Urolithiasis. Urol. Clin. N. Amer., 1:247, 1974.
7. Drylie, D. M.: Fewer Renal Stones in Hard Water Areas. Urol. News Vol. 3:1, January, 1975.

There are two swift ways to tell when the Mississippi Legislature is in town: 1. You can't find a parking place around the Capitol; 2. Sen. Theo Smith of Corinth starts issuing profound statements twice a day. Sorta like the swallows returning to Capistrano.

—Jimmy Ward
Jackson Daily News

12-hour claims
are nothing new.

12-hour relief is.



NEW

Novafed® A Capsules

Each capsule contains pseudo-ephedrine hydrochloride 120 mg. and chlorpheniramine maleate 8 mg.

Controlled-Release Decongestant Plus Antihistamine

It goes the distance.





Clinical studies confirm full 12-hour effectiveness.

For years, patients have heard of drugs providing long-lasting relief. But after six or eight hours, they often run out of relief. And it's too soon to take the next dose.

Now, with Novafed A, Dow introduces a prescription capsule with 12-hour effectiveness in relieving allergy and hay fever symptoms. Placebo-controlled clinical studies show that the high level of decongestant in Novafed A provides relief for as long as 12 hours. At the same time, its antihistamine relieves the patient's itchy eyes and runny nose *without* the excessive dryness of anticholinergic agents.

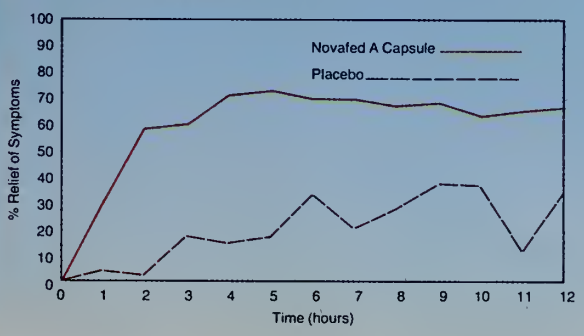
Prompt onset of effect is followed by full 12-hour relief.

(Please refer to the following page for bioavailability studies and prescribing information.)



Patients with severe pollen allergies were tested during hay fever season in a countryside environment and asked to rate severity of five different symptoms on a scale of 1 to 4.

Clinical Study: Degree of Relief from Itchy Eyes and Nose and Throat, Watery Eyes, Runny Nose*



*Unpublished data, Medical Department Files, Dow Pharmaceuticals, The Dow Chemical Company, Indianapolis, Indiana.

DOW

Specialists in Cough and Cold Care





NEW

Novafed® A Capsules

Each capsule contains pseudoephedrine hydrochloride 120 mg. and chlorpheniramine maleate 8 mg.

Controlled-Release Decongestant Plus Antihistamine

It goes the distance.



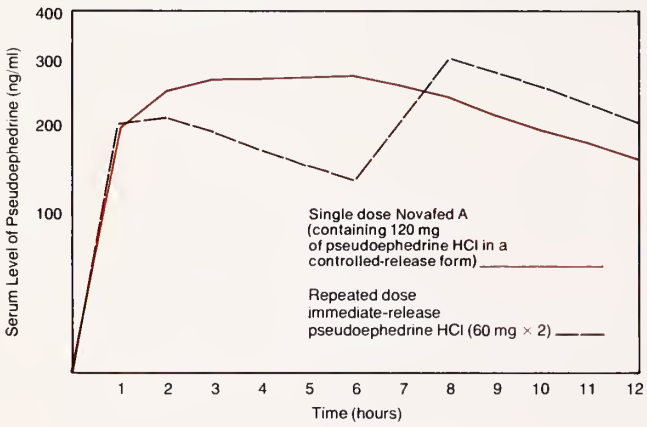
Prompt onset and sustained serum levels over 12 hours.

A bioavailability study confirmed that the sustained 12-hour action of Novafed A was comparable to that of immediate-release medication taken at 6-hour intervals.

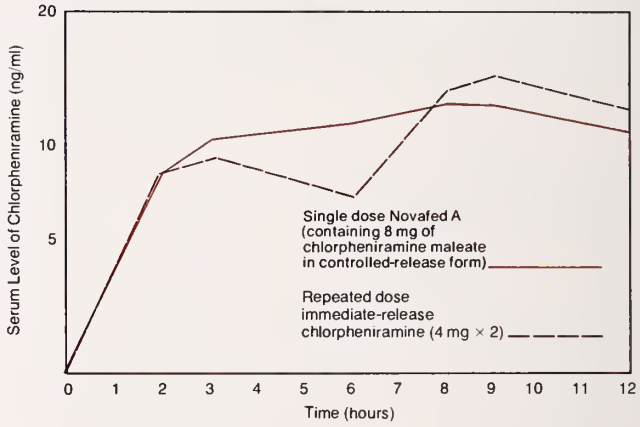
The chart at the left shows the serum levels of pseudoephedrine. Initial serum levels following one Novafed A Capsule were comparable to those following a single dose of 60 mg. pseudoephedrine hydrochloride in an immediate-release form. Serum levels of pseudoephedrine over a 12-hour period following a single dose of Novafed A were also comparable to those obtained by an immediate-release form taken every 6 hours.

The chart at the right shows the serum levels of chlorpheniramine. Initial serum levels following one Novafed A Capsule were comparable to those following a single dose of 4 mg. chlorpheniramine maleate in an immediate-release form. Serum levels of chlorpheniramine over a 12-hour period following a single dose of Novafed A were also comparable to those obtained by an immediate-release form taken every 6 hours.

Comparison of Mean Serum Levels of Pseudoephedrine Following Novafed A and an Immediate-Release Reference Formulation*



Comparison of Mean Serum Levels of Chlorpheniramine Following Novafed A and an Immediate-Release Reference Formulation*



*Unpublished data, Medical Department Files, Dow Pharmaceuticals, The Dow Chemical Company, Indianapolis, Indiana.

DESCRIPTION: Each NOVAFED A capsule contains 120 mg. of pseudoephedrine hydrochloride and 8 mg. of chlorpheniramine maleate. The specially formulated pellets in each capsule are designed to provide continuous therapeutic effect for about 12 hours. Nearly one-half of the active ingredients is released soon after administration and the remainder is released slowly over the remaining time period.

ACTIONS: NOVAFED A combines the action of a nasal decongestant, pseudoephedrine hydrochloride, and an antihistamine, chlorpheniramine maleate. These ingredients are combined to provide prompt and sustained nasal and upper respiratory decongestant and antihistaminic action.

INDICATIONS: NOVAFED A is indicated for the relief of nasal congestion and eustachian tube congestion associated with the common cold, sinusitis and acute upper respiratory infections. It is also indicated for perennial and seasonal allergic rhinitis, vasomotor rhinitis, allergic conjunctivitis due to inhalant allergens and foods and for mild, uncomplicated allergic skin manifestations of urticaria and angioedema. Oecongestants in combination with antihistamines have been used for many years to relieve eustachian tube congestion associated with acute eustachian salpingitis, aerotitis media, acute otitis media and serous otitis media. NOVAFED A may be given concurrently, when indicated, with analgesics and antibiotics.

CONTRAINDICATIDNS: Symphathomimetic amines are contraindicated in patients with severe hypertension, severe coronary artery disease, and in patients on MAO inhibitor therapy. Antihistamines are contraindicated in patients with narrow-angle glaucoma, urinary retention, peptic ulcer, during an asthmatic attack, and in patients receiving MAO Inhibitors.

Children under 12: NOVAFED A controlled-release capsules should not be used in children less than 12 years of age.

Nursing Mothers: Pseudoephedrine is contraindicated in nursing mothers because of the higher than usual risk for infants from sympathomimetic amines.

Hypersensitivity: This drug is contraindicated in patients with hypersensitivity or idiosyncrasy to sympathomimetic amines or antihistamines. Patient idiosyncrasy to adrenergic agents may be manifested by insomnia, dizziness, weakness, tremor or arrhythmias.

WARNINGS: Sympathomimetic amines should be used judiciously and sparingly in patients with hypertension, diabetes mellitus, ischemic heart disease, increased intraocular pressure, hyperthyroidism, or prostatic hypertrophy. Sympathomimetics may produce central nervous system stimulation and convulsions or cardiovascular collapse with accompanying hypotension.

Antihistamines may impair mental and physical abilities required for the performance of potentially hazardous tasks, such as driving a vehicle or operating machinery, and mental alertness in children. Chlorpheniramine maleate has an atropine-like action and should be used with caution in patients with increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension or in patients with a history of bronchial asthma.

Oo not exceed recommended dosage.

Use In Pregnancy: The safety of pseudoephedrine for use during pregnancy has not been established.

Use In Elderly: The elderly (60 years and older) are more likely to have adverse reaction to sympathomimetics. Overdosage of sympathomimetics in this age group may cause hallucinations, convulsions, CNS depression, and death. Therefore, safe use of a short-acting sympathomimetic should be demonstrated in the individual elderly patient before considering the use of a sustained-action formulation.

PRECAUTIONS: This drug should be used with caution in patients with diabetes, hypertension, cardiovascular disease and hyperreactivity to ephedrine. The antihistaminic may cause drowsiness and ambulatory patients who operate machinery or motor vehicles should be cautioned accordingly.

ADVERSE REACTIONS: Hyperreactive individuals may display ephedrine-like reactions such as tachycardia, palpitations, headache, dizziness, or nausea. Patients sensitive to antihistamines may experience mild sedation.

Sympathomimetic drugs have been associated with certain untoward reactions including fear, anxiety, tenseness, restlessness, tremor, weakness, pallor, respiratory difficulty, dysuria, insomnia, hallucinations, convulsions, CNS depression, arrhythmias, and cardiovascular collapse with hypotension.

Possible side effects of antihistamines are drowsiness, restlessness, dizziness, weakness, dry mouth, anorexia, nausea, headache and nervousness, blurring of vision, heartburn, dysuria and very rarely, dermatitis.

DRUG INTERACTIONS: MAO inhibitors and beta adrenergic blockers increase the effect of sympathomimetics. Sympathomimetics may reduce the antihypertensive effects of methyldopa, mecamylamine, reserpine and veratrum alkaloids. Concomitant use of antihistamines with alcohol, tricyclic antidepressants, barbiturates and other central nervous system depressants may have an additive effect.

DDSAGE AND ADMINISTRATION: One capsule every 12 hours. Oo not give to children under 12 years of age.

CAUTION: Federal law prohibits dispensing without prescription.

HOW SUPPLIED: NOVAFED A is supplied in red and orange colored hard gelatin capsules, monogrammed with the Oow diamond followed by the number 109, in bottles of 100.

DOW

DOW PHARMACEUTICALS
The Dow Chemical Company
Indianapolis, IN 46268

Specialists in cough and cold care

Radiologic Seminar CLIX: Pulmonary Overaeration in Infancy

BERNARD I. BLUMENTHAL, M.D.
Jackson, Mississippi

DURING INFANCY the most common clinical manifestations of lower respiratory tract infection are expiratory dyspnea and over-expansion of the chest.[1] The most common radiographic manifestation of these respiratory disturbances is diffuse overaeration of the lungs alone or with varying amounts of visible infiltration, consolidation, or atelectasis. This radiographic picture reflects diffuse involvement of the lungs and presumably the distribution of exudate in and around the bronchi and bronchioles.

In the older child and adult it is possible to radiographically designate various forms of pulmonary infection on the basis of the anatomic distribution of the exudate. In the infant under 12-15 months of age this separation is not possible. The infant's pulmonary response to a great variety of organisms and agents tends to be similar and to be manifest as diffuse pulmonary involvement. In view of the nonspecificity of the roentgen manifestations of pulmonary disease in infants it would seem preferable to label these changes as "diffuse interstitial inflammatory disease" and to designate the specific etiology later as the clinical course unfolds and other laboratory data become available. The early radiograph of the child with bronchiolitis is indistinguishable from that of a child with early bacterial infection or aspiration. Clues as to the specific etiological diagnosis may only appear on later radiographs.

The pathogenesis of pulmonary overaeration in the young child is not completely understood, but is probably the result of partial bronchiolar obstruction.[2] Mild bronchiolar mucosal edema and/or spasm causes a check-valve[3] bronchiolar obstruction with resultant distal air-trapping. As the inflammatory process progresses there is edema of the bronchiolar interstitial tissue and adjacent alveolar spaces. Only when the inflammation is prolonged and severe can identifiable alveolar exudate be expected. Retained secretions in the bronchial tree may be responsible for segmental or lobar atelectasis. When the small airway obstruction is severe, there may be rupture of the alveoli or alveolar ducts and dissection of air into the interstitial tissue, mediastinum or pleural space.

Diffuse overaeration of the lungs is the initial and most important roentgen manifestation of pulmonary disease in the young child. The vascular shadows are separated and, in the absence of visible exudate, are seen as distinct tapering and branching structures. The overaeration is usually generalized, but, at times, may be greater in one segment or lobe.

Depression of the diaphragm will be evident in both frontal and lateral radiographs (see Figure 1). The anterioposterior dimension of the thorax will be increased, especially below the thoracic inlet. Substernal retractions may be evident and parallel the degree of diaphragmatic depression. The anterior ends of upper ribs will be elevated and the interspaces widened. In severe overaeration the lungs seem to bulge between the rib interspaces.

Visible infiltration tends to be linear and, because of its peri-interstitial location, follows the distribution of the bronchial tree. When minimal, the infiltration may be manifest only by unsharpness of the peripheral vascular structures in the proximity of the involved small airways. Bronchial involvement may be appreciated when the bronchi are seen on-end and the thickened wall is apparent. Further parenchymal involvement will be evident as localized areas of consolidation superimposed upon the overaeration and diffuse peribronchial infiltration. Segmental or lobar atelectasis is most common in the dependent portion of the lung and reflects bronchial or bronchiolar obstruction by exudate. When the peribronchial infiltration is minimal, it tends to become most evident as the overaeration resolves.

Acute bronchiolitis is one of the most common forms of diffuse interstitial inflammatory disease in infants and children under the age of three years. A

Sponsored by Mississippi Radiological Society.
From the Department of Radiology, University of Mississippi Medical Center, Jackson, Miss.

virus, commonly the respiratory syncytial virus, is the usual etiologic agent.[4] Overaeration of the lungs is the initial roentgen finding no matter what the etiologic agent. This is followed by visible infiltrate, patchy consolidation and/or atelectasis. Depending on the organism and the host's response to infection, parenchymal densities are seen in greater or lesser amounts.

About 50 per cent of the children admitted to the hospital have a clinical and/or radiographic diagnosis of pneumonia.[5] Definitive proof of the etiology of these pneumonias requires isolation of the pathogen from blood, pleural fluid, or lung aspirate. It is estimated that 10 to 20 per cent of the pneumonias in hospitalized children are caused by bacteria.[6] Staphylococcal pneumonia accounts for one-third of the primary bacterial pneumonias in children under the age of two years.[4] Staphylococcal infection is often manifest as initial overaeration rapidly followed, within 8 to 12 hours, by localized consolidation of a lung or a lobe and by pleural involvement (see Figure 2). The pneumonia may progress to pneumatocele formation (13 per cent) or pneumothorax (21 per cent).[7] Consolidation, empyema and pneumatoceles can also be seen in infection with beta-hemolytic streptococcus[8] and Haemophilus influenzae.[9]

Aspiration of swallowed material because of pharyngeal dysfunction or esophageal lesions will result in pulmonary overaeration and parenchymal densities. The distribution of the parenchymal density varies with the age of the child; upper lobe in the recumbent infant, and basilar in the erect toddler or older child (see Figure 3).

The most common cause of generalized pulmonary overaeration in the older child is asthma. At times, asthma will present in infancy. Radiographically the pattern in the infant is that of early diffuse interstitial inflammatory disease and is indistinguishable from the picture associated with the great variety of etiologic agents. In asthma visible infiltrate is generally minimal (see Figure 4, page 42).

Pulmonary manifestations of cystic fibrosis of the pancreas are characterized by overaeration of the lungs, peribronchial and peribronchiolar infiltrate, cystic dilatation of bronchi and bronchioles, and patchy consolidations. The upper lobes tend to be the first involved. Early in the course of the disease the only roentgen manifestations may be overaeration of the lungs and minimal infiltrate; at this time a specific radiologic diagnosis is not possible (see Figure 5, page 42).

Overaeration of the lungs is also seen in infants with congenital heart disease, particularly in left-to-right shunts and in obstruction to pulmonary venous return. The severely dehydrated infant will also exhibit pulmonary overaeration on the basis of hypovolemia and metabolic derangement; in this situation the heart may be small and no infiltrate will be present.

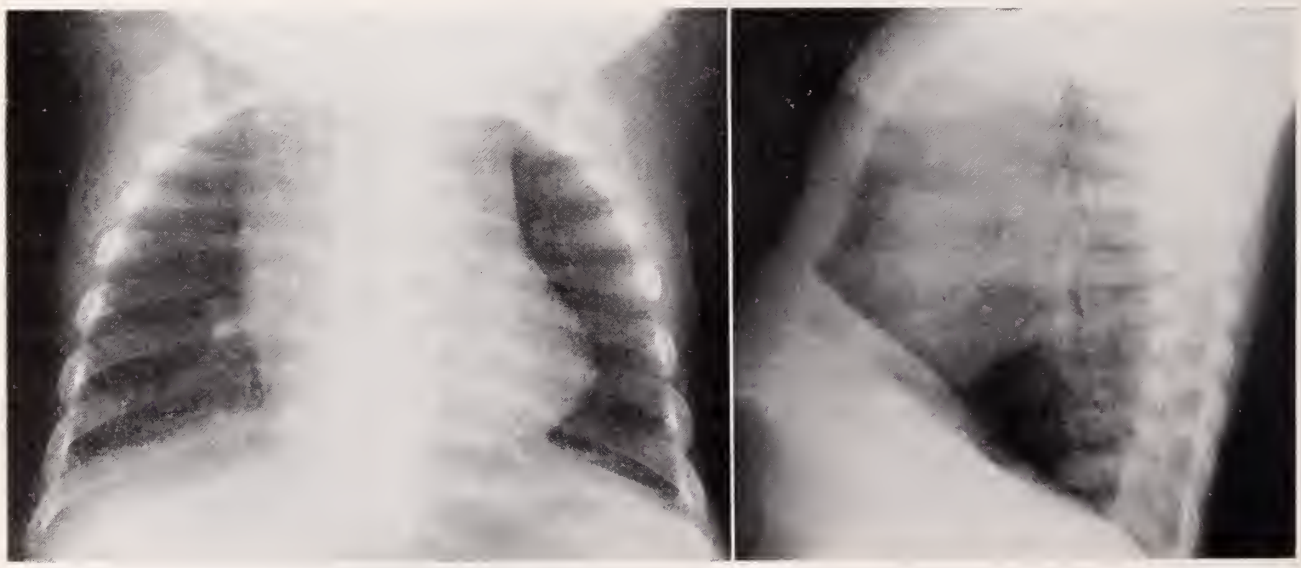


Figure 1. AP and lateral chest. Six-month-old child with a one-day history of cough and fever. The diffuse pulmonary overaeration and indistinctness of the peripheral lung markings are characteristic of diffuse interstitial inflammatory disease.



Figure 2. AP and lateral chest. Eight-month-old child with a one-week history of prostration and productive cough. The lungs are diffusely overaerated. There is consolidation of the left lower lobe with a left pleural effusion and cystic areas within the consolidated lobe. Diagnosis is staphylococcal pneumonia.



Figure 3. AP and lateral chest. One-and-a-half-year-old child who ingested an unknown quantity of lighter fluid. There is diffuse overaeration and a typical bibasilar infiltrate characteristic of hydrocarbon pneumonitis.

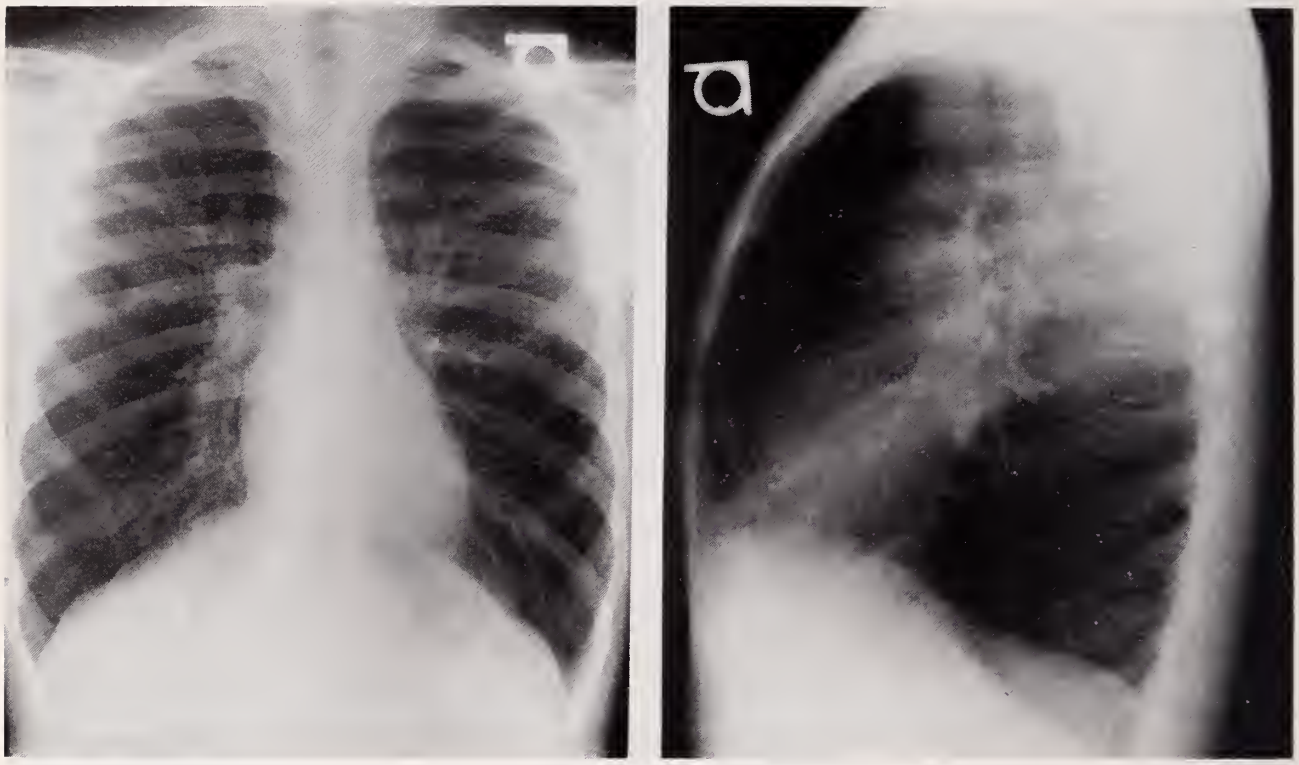


Figure 4. PA and lateral chest. Eleven-year-old with six-hour history of dyspnea and wheezing. The lungs are markedly overaerated. There is no parenchymal infiltrate present. The central pulmonary arteries are prominent. Diagnosis is asthma.

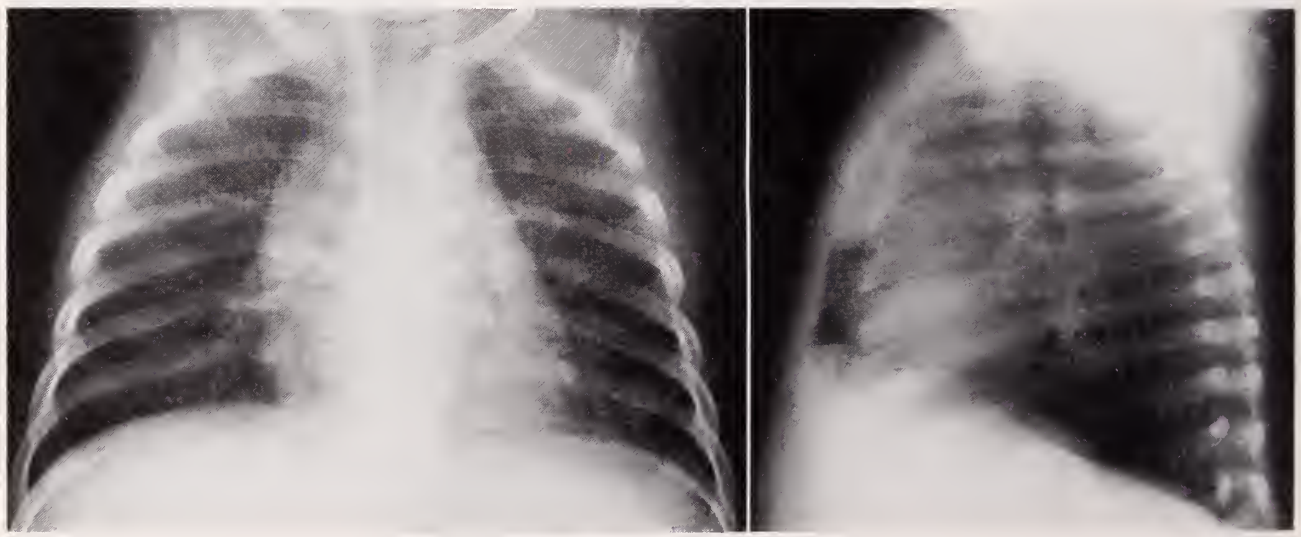


Figure 5. PA and lateral chest. Six-month-old infant with chronic cough. The lungs are overaerated and the lung markings are indistinct. A positive sweat test provides this diagnosis: pulmonary manifestation of cystic fibrosis of the pancreas.

SUMMARY

The radiographic manifestations of a variety of pulmonary disturbances encountered in the first year of life are those of diffuse pulmonary overaeration associated with varying degrees of visible infiltration. Overaeration of the lungs is the initial finding and may be the only manifestation of a number of disease processes. One should not expect lobar or patchy consolidation as seen in the older child or adult in infants with pulmonary inflammation. One cannot equate the severity of the clinical findings with the amount of pulmonary parenchymal density apparent radiographically in the infant or young child. ★★★

2500 North State Street (39216)

REFERENCES

1. Nelson, W. E., Ed.: Textbook of Pediatrics. Philadelphia, W. B. Saunders Co., 1964.
2. McLean, K. H.: The Pathology of Pulmonary Emphysema. Am. J. Med. 25:62-74, July 1958.
3. Caffey, J.: Pediatric X-ray Diagnosis. Chicago, Yearbook Medical Publishers, 1972.
4. Smith, C. B. and Overall, J. C.: Clinical and Epidemiologic Clues to the Diagnosis of Respiratory Infections. Radiol. Clin. N.A. 11:261-268, August 1973.
5. Macaset, F. F., Kidd, P. A., Bolano, C. R., et al: The Etiology of Acute Respiratory Infections, III. The Role of Viruses and Bacteria. J. Pediat. 72:829-839, June 1968.
6. Mufson, M. A., Kruse, H. E., Moceya, H. E., et al: Viruses, Mycoplasma Pneumoniae and Bacterial Associated With Lower Respiratory Tract Disease Among Infants. Am. J. Epidemiol. 91:192-202, February 1970.
7. Rebhan, A. W. and Edwards, H. E.: Staphylococcal Pneumonia: A Review of 329 Cases. J. Can. Med. Assoc. 82:513-517, March 5, 1960.
8. Kevy, S. V. and Lowe, B. A.: Streptococcal Pneumonia and Empyema in Childhood. New Eng. J. Med. 264:738-743, April 14, 1961.
9. Kendig, E. L., Jr.: Pulmonary Disorders, Vol. I. Disorders of the Respiratory Tract in Children. Philadelphia, W. B. Saunders Co., 1972.

A girl, shopping for a gift for her brother, noticed a handsome pair of men's pajamas and asked the price. The clerk said, "They're $42.50."

Heading for the necktie department, the girl exclaimed, "For $42.50, they should have a man in them!"

A Review of the Mississippi Professional Standards Review Organization Screening Criteria for Diabetes Mellitus

THIS ARTICLE continues the JOURNAL MSMA series on the work of the Professional Standards Committee of the Mississippi Foundation for Medical Care. This committee is charged with directing the development of screening criteria for use by Mississippi hospitals implementing the foundation's concurrent review process. Assisting in this task are multispecialty criteria review panels composed of Mississippi physicians. The present article addresses in detail a specific criteria set which was established by one of the criteria review panels. As with all criteria sets, it is subject to review and change.

Screening criteria for diabetes mellitus were established by the Metabolic and Endocrine Criteria Review Panel. This criteria set will appear in the MFMC/PSRO screening criteria manual scheduled for publication early in 1976. The panel is composed of six physicians, two each from northern, central and southern Mississippi, and the specialties of family medicine, internal medicine, pediatrics and surgery are represented.

Screening for diabetes mellitus will appear in the PSRO manual as follows:

Diabetes Mellitus
H-ICDA Code 250
PAS Table #67, #68, #69

I. Admission Indicators
   1. Emergency
      1.1 Insulin shock or coma
      1.2 Diabetic acidosis
      1.3 Severe or frequent hypoglycemic reaction(s)
   2. Nonemergency
      2.1 Poorly controlled diabetes
      2.2 New diabetic patient where regulation or control cannot be established as an outpatient

II. Essential Services
   a. History and physical examination—90220
   b. CBC—85010
   c. Urinalysis—81000
   d. Fractional urines for sugar and acetone—84362, 84365
   e. Serum glucose—84330

III. Diagnostic Services Consistent with this Diagnosis
   a. Clinical Laboratory
      1. Serum acetone—82010
      2. Serum electrolytes—82685
      3. Thyroid function studies—83420-83490 (includes T_3, T_4, PBI)
      4. Serum lipids—83700
      5. Lipoprotein electrophoresis—83715
      6. Quantitative urine protein—84180
      7. Glucose tolerance test—84340-84360
      8. BUN—84520
      9. Serum uric acid—84550
      10. Urine culture and sensitivities—87085
   b. Radiology
      1. Abdominal x-ray—74000
   c. Cardiovascular Diagnostic Services, Non-Invasive
      1. EKG—93000
   d. Miscellaneous Diagnostic Services
      1. Electroencephalogram—95820

   (The numbers following the service represent the CPT code which is used for tabulation and audit purposes.)

IV. Management Consistent with this Diagnosis
   a. Drugs
      1. Anti-infectives—08:00
      2. Electrolytes (to include sodium bicarbonate)—40:08/40:12
      3. Diuretics—40:28
      4. Anti-diabetic agents—oral—68:20
      5. Glucagon—68:20
      6. Insulin—68:20.08

   (The number following the drug is a code based on the American Hospital Formulary Service and is used for tabulation and audit purposes.)
   b. Dietary consultation and management

V. Indications for Discharge
   a. Absence and/or control of signs and symptoms
   b. Maximum benefits of hospitalization achieved

VI. Validation of Diagnosis
   a. Documentation of physical and clinical manifestation of diagnosis
   b. Laboratory findings

In addition to the above criteria which were developed specifically for diabetes mellitus, the Standards Committee also recognizes that there are certain diagnostic services, treatments, and medications which may be common to multiple diagnoses and therefore, may be listed in the front of the manual without needless repetition in each disease

From the Professional Standards Committee, Mississippi Foundation for Medical Care, Inc., Jackson.

specific criteria set. Examples include admission chest x-rays, SMA profiles, laxatives, and bedtime hypnotics. The diagnostic services and items of management consistent with all diagnoses which are listed in the manual are as follows:

Diagnostic Services and Management Consistent with all Diagnoses

Diagnostic Services Consistent with all Diagnoses
(These services may be provided to selected patients regardless of the primary admitting diagnosis.)

1. SMA profile tests
   a. SMA 6
   b. SMA 12
   c. SMA 16
   d. SMA 18
   e. SMAC
   f. SMA (other)
2. P.K.U., Blood
3. Sickle cell prep
4. Serology
5. Tuberculin skin test
6. Wound culture
7. Autopsy
8. Pap smear
9. Chest x-ray (PA, or PA and lateral)
10. Consultation
    a. Medical—90640-90683
    b. Dental—90685
    c. Social service—90695
    d. Dietary—90690
    e. Other—90699
11. EKG (age 40 or over)

Management Consistent with all Diagnoses

1. Drugs
   a. Analgesics (narcotic and non-narcotic)
   b. Antinauseants (antimetics)
   c. Antipyretics
   d. Ataractics/tranquilizers
   e. Cough and cold preparations
   f. Hypnotics
   g. Laxative and/or stool softeners
   h. Sedatives
   i. Vitamin supplement
2. Proctosigmoidoscopy
3. Special and environmental care units, such as:
   a. ICU
   b. CCU
   c. Premature nursery
   d. Isolation unit
   e. Burn unit
   f. Recovery room (more than one day)
   g. Dialysis unit
   h. Cardiovascular intensive care unit
   i. Child psychiatric units
   j. Adolescent psychiatric units
   k. Thermoregulatory devices
   l. Other
4. Medical consultations (to include all medical specialties)
   a. Medical—90640-90683
   b. Dental—90685
   c. Social service—90695
   d. Dietary—90690
   e. Other—90699
5. Parenteral fluids
6. Diet therapy or consultations
7. Oxygen therapy in instances of intermittent or respiratory distress and/or shock

In addition to the above, factors influencing the length of stay have been developed as universal criteria for all diagnoses:

Factors Extending Length of Stay

1. Unresolved admitting diagnosis or problem
2. Concomitant disease or condition
3. Postoperative complication
4. Adverse reaction to therapy
5. Extended therapy program
6. Social factors

COMMENTS

The criteria indicate that there are three emergency admission indicators for diabetes mellitus. An emergency admission occurs when the patient requires immediate or prompt care (within 24 hours) which may be obtained only in a hospital setting. The emergency admission indicators are:

1. Insulin shock or coma
2. Diabetic acidosis
3. Severe or frequent hypoglycemic reactions

Nonemergency admission indicators are limited to "poorly controlled diabetes" and "new diabetic where regulation or control cannot be established on an outpatient basis." A nonemergency admission does not meet the emergency 24 hour requirement but, nevertheless, is an admission for definite indications. All emergency indicators may additionally be used as nonemergency indicators when specified by the admitting physician. For example, milder forms of hypoglycemic reactions present for a number of weeks may be used as a nonemergency indicator.

The Essential Services required for all patients entering the hospital with diabetes mellitus are:

1. History and physical examination
2. Complete blood count (CBC)
3. Urinalysis
4. Fractional urines for sugar and acetone
5. Blood glucose

In actuality, the history and physical examination, CBC and urinalysis are required for all patients. The Metabolic and Endocrine Panel added "fractional urines for sugar and acetone" and "blood

glucose" to the essential services list. These services must be provided for 100 per cent of patients being admitted with the diagnosis (or suspected diagnosis) of diabetes. As with all criteria sets developed, the essential service requirement for diabetes is not lengthy. The purpose of screening criteria is to provide an effective review mechanism rather than to establish rigid standards of quality. Several hospital medical staffs have added to the essential services required by the MFMC/PSRO criteria in order to comply with their own locally established level of excellence.

In addition to the essential services, there are a number of services listed in section III which are consistent with the diagnosis of diabetes. These services, while not essential and required, are appropriate patient care services which may be provided.

Management consistent with diabetes is outlined in section IV. These drugs or classes of drugs may or may not be indicated as the attending physician determines. The physician is not limited to these forms of therapy. If there are complications, concomitant disease, or secondary diagnoses, all of the diagnostic services and management criteria of these other problems may also apply to the patient. Individual initiative and individuality in patient care are encouraged. The Metabolic and Endocrine Panel have simply set forth what they believe are the most commonly used diagnostic services and forms of therapy.

The indications for discharge of a patient with diabetes from the hospital are the "absence and/or control of signs and symptoms," and "maximum benefits of hospitalization achieved." These two items represented what the panel felt would be sufficient evidence that the diabetic patient had received the maximum benefits of hospitalization. The progress notes should reflect that one or both of these criteria have been achieved.

Validation of diagnosis refers to those items, obtainable in retrospect from the medical record, which document that the patient had the disease or problem for which he was admitted and treated. In the case of diabetes mellitus, validation of the diagnosis was felt to be sufficiently verified if the medical record contained "documentation of the physical and clinical manifestation of the diagnosis" and/or supporting "laboratory findings."

Criteria sets similar to the one presented above have been or are currently being developed for approximately 150 other diagnoses and problems. All are subject to review and revisions as they are used and tested in hospitals throughout Mississippi. Suggestions by physician readers concerning this criteria set or the general format being utilized would be appreciated and given careful attention. ★★★

P.O. Box 4665 (39216)

A censor banned the book, "Fun in Bed." Then he found out it was about games for sick children.

"Kid, this stuff is the bananas."



Experts agree: when it comes to good-tasting banana flavor—without the unpleasant taste of paregoric—the makers of Donnagel®-PG really know their stuff!

For diarrhea

Donnagel-PG ℣

Donnagel with paregoric equivalent

Each 30 cc. contains:	
Kaolin	6.0 g.
Pectin	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Powdered opium, USP (equivalent to paregoric 6 ml.) (warning, may be habit forming)	24.0 mg.
Sodium benzoate (preservative)	60.0 mg.
Alcohol, 5%	

Now with child-proof closure

A·H·ROBINS

A.H. Robins Company
Richmond, Virginia 23220

IN COUGHS OF COLDS, 'FLU, AND U.R.I.- CLEAR THE TRACT WITH THE ROBITUSSIN® LINE



THE 5 RELIABLE ROBITUSSINS can really help clear the respiratory tract. All contain guaifenesin,* the expectorant that works systemically to help stimulate the output of lower respiratory tract fluid. This enhanced flow of less viscid secretions promotes ciliary action and makes thick, inspissated mucus less viscid and easier to raise.

*formerly named Glyceryl Guaiacolate

For productive and unproductive coughs

ROBITUSSIN®

Each 5 ml teaspoonful contains:
Guaifenesin, NF. ..... 100 mg
Alcohol, 3.5%

For severe coughs

ROBITUSSIN A-C® Ⓥ

Each 5 ml teaspoonful contains:
Guaifenesin, NF. ..... 100 mg
Codeine Phosphate, USP. ..... 10.0 mg
(warning: may be habit forming)
Alcohol, 3.5%

Non narcotic for 6-8-hr. cough control

ROBITUSSIN-DM®

Each 5 ml teaspoonful contains:
Guaifenesin, NF. ..... 100 mg
Dextromethorphan Hydrobromide, NF. ..... 15 mg
Alcohol, 1.4%

Decongests nasal passages and sinus openings as it helps relieve coughs

ROBITUSSIN-PE®

Each 5 ml teaspoonful contains:
Guaifenesin, NF. ..... 100 mg
Pseudoephedrine** Hydrochloride, NF. 30 mg
Alcohol, 1.4%
**Formerly contained Phenylephrine Hydrochloride 10 mg

Decongestant action helps control cough and clear stuffy nose and sinuses. Non narcotic.

ROBITUSSIN-CF®

Each 5 ml teaspoonful contains:
Guaifenesin, NF. ..... 50 mg
Phenylpropanolamine Hydrochloride, NF 12.5 mg
Dextromethorphan Hydrobromide, NF. . . 10 mg
Alcohol, 1.4%

All Robitussin formulations available on your Rx or Recommendation.

A. H. Robins Company, Richmond, Va 23220 A·H·ROBINS

For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines. In keeping with this tradition, the company recently commissioned a well-known illustrator to render full-color drawings of several classic locomotives... accurate to the minutest detail. The first of the series is now available. To order your print suitable for framing, write "Robitussin Clear-Tract Engine #1" on your Rx pad and mail to "Vintage Locomotives," Dept. T4, A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220.



The William Mason (1856)



The President Speaking

"The Credibility Gap"

JACK A. ATKINSON, M.D.
Brookhaven, Mississippi

JOHN W. RESTON, respected editorialist for the *New York Times,* described the mood of America by writing, several years ago, "There is a widespread uncertainty among our people." I regard that as an understatement.

Crises in the economy, energy, health care, and politics come so rapidly that, like the White Queen in *Alice in Wonderland,* we are asked to believe "six impossible things before breakfast." Underneath these issues there is a more basic conflict about values—about good and evil, justice and injustice, truth and falsity. Such fundamental issues inevitably arise in times of transition and upheaval, in times when one era, one age, one epoch comes to an end and before another is born. We may well be one of several generations compelled to live through such a period.

The uncertainty that accompanies our period of transition is ofttimes described as a "credibility gap." A recent Harris poll indicates a dramatic drop of public confidence in basic American Institutions in the decade 1965-1975. Business leaders, according to the poll, have fallen in public esteem from a 55 per cent vote of confidence in 1965 to a 15 per cent vote of confidence in 1975; religious leaders from 41 per cent to 29 per cent, leaders in higher education from 61 per cent to 34 per cent.

The reason I write of this "credibility gap" is to caution that we, as physicians, should not overreact to the current critical attack upon the profession. In spite of the verbal attacks presented in the popular press and on the television screen, the medical profession, according to the poll mentioned, is still held in higher regard than any other professional group. Such attacks as we undergo have to be seen in the context of a culture-wide vacuum of confidence.

Political scientists tell us that national moods, like those of people, have highs, lows, and times of uncertainty and conflict. In such an era I believe we can best counter the attacks against us by doing the thing we do the very best and that is by continuing to provide the highest quality medical care for our patients. ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XVII, NUMBER 2
FEBRUARY 1976

EDITORIALS

Management of Head and Neck Tumor

Malignant tumors of the head and neck region contribute to approximately 5.5 per cent of the cancer deaths in this country. The majority of these lesions are squamous cell carcinoma. Etiologically, tobacco usage in any form figures prominently in this tumor incidence. Recently alcohol has been implicated as an etiologic agent, substantiating what many of us have long recognized. Continued use of these agents after recognition and treatment of a primary lesion is associated with a greater incidence of second primary tumors. The incidence of multiple primary tumors seems to be greater in the head and neck than in other areas.

Unfortunately head and neck cancers are among the most serious tumors. Utilizing present treatment modalities, carcinoma of the nasopharynx has a curability of 30-35 per cent, tonsil 25 per cent, base of tongue 20 per cent, sinuses 30 per cent, and temporal bone 30 per cent. Cancer of the larynx stands out as the only bright star, with a cure rate of 60 to 90 per cent, depending upon the stage of the lesion when initially seen.

Management of head and neck cancer is often complicated by cosmetic deformities and/or loss of vital functions such as speech, smell, hearing, vision, or the ability to swallow. These factors strongly influence a patient when deciding on therapy. Many physicians also fail to realize the impact these losses have on patients and offer little help in adjusting or recovering from such deficits.

Over 100 years ago Bilroth performed the first laryngectomy for carcinoma of the larynx. From 1875 to the early 1900's surgery, thought generally inadequate, remained the only modality of treatment. The discovery of roentgen rays, radium, and radiation therapy early in this century provided a helpful, but not totally adequate means of handling these lesions. Arrival of the antibiotic era in the early 1940's led to rapid advances in the field of surgery. These were reflected in the "combined" or "composite" resection of malignant lesions of the head and neck region. Concurrently rapid advances were made in the fields of radiation physics and therapy. New fields in chemotherapy and immunotherapy emerged. Because of the unique problems encountered by this group of patients and these recent developments a new "multidisciplinary approach" to management has emerged. In this team approach all concerned with management of any phase of the treatment jointly decide on a total therapeutic plan from start to rehabilitation and the part each is to play. Anything less than this widely based approach is inadequate, inappropriate, and out of step with recent developments. Therefore, before embarking on any treatment be sure that the surgeon, or surgeons, radiation therapist, internist, and rehabilitation personnel all know and chart what is to take place and understand the time schedule for achieving the same. No longer is it adequate to do something and if it fails call in another member of the team.

MYRON W. LOCKEY, M.D.
Jackson, MS
Associate Editor

Dramatic Change Occurs In Medical Education

A recent issue of the *Journal of the American Medical Association* indicates the dramatic change that has taken place in medical education during the past decade.

In a year end medical education issue, *JAMA* reports that medical school enrollment has increased from 32,835 students in 1965 to 55,818 students in 1975, a 70 per cent gain in 10 years. Also, 58 per cent of last year's 6,741 medical graduates entered "primary care" residencies (i.e., family practice, internal medicine, ob-gyn and pediatrics) compared to 38 per cent of the graduates as recently as 1968.

In Mississippi, medical school enrollment has increased from 288 students in 1965 to 530 students in 1975, an 84 per cent increase, and a University Medical Center spokesman states that 60 per cent of this year's senior medical class has indicated an interest in primary practice.

The number of medical schools has increased from 89 a decade ago to 114 with 11 more on the planning board, and the one-year internship has virtually disappeared becoming part of a longer, more detailed hospital residency, usually lasting at least three years.

The number of women in first year medical classes has risen from 9 per cent to 23 per cent but the number of black students will decline this fall, after several years of increases, and blacks will compose 6.5 per cent of medical school enrollment. The latter may be due in large part to a sharp increase in medical school tuition over the past few years while both federal and private student loan funds have declined.

Charles L. Mathews
Executive Secretary

Medico-Legal Briefs

RELEASE OF MOTORIST NO ABSOLUTE BAR TO MALPRACTICE SUIT

Release of a negligent motorist involved in an accident which injured a motorcyclist did not necessarily bar a later suit for malpractice against a treating physician and a hospital, the highest court of West Virginia ruled.

After the accident, the patient settled his claim against the driver of the car for $10,000. The motorist signed a release from all claims arising from the accident. When he attained the age of majority a few years later, the patient filed a malpractice suit against his treating physician and the hospital. Contending that their negligent treatment aggravated his injuries, he sought $500,000 in damages.

Based on earlier decisions, the trial court granted summary judgment in favor of the physician and the hospital. The court said that an unqualified release of the original wrongdoer prevented any further recovery from treating physicians and hospitals for negligent treatment which may have aggravated the original injuries. The patient appealed.

On appeal, the highest court of West Virginia pointed out that an injured person may recover only once for the damages he suffers. A subsequent injury resulting from negligent treatment by a physician is part of the direct damages flowing from the original injury. The original wrongdoer is liable for all damages, including those inflicted by the physician.

Reviewing the trend in other jurisdictions, the high court said it would choose to follow the modern rule that a release does not necessarily bar a further recovery against a physician or hospital that independently treats an injured person. Under this rule, the patient would be permitted to present evidence explaining the intention of the parties at the time the release was signed. The release would not be an irrebuttable presumption that the injured person recovered complete satisfaction for his injuries, including those suffered at the hands of a negligent hospital or physician.

The old rule was unfair because of the presumption that absolutely barred a second action by an injured person for aggravating the injury. It was unreasonable to conclude that an injured person meant to excuse his physician or hospital from negligence when he released a motorist who struck his motorcycle and injured him, the court said.

Moreover, an injured person has a separate cause of action against a successive and independent physician or hospital who negligently renders treatment for injuries caused by another person. For those reasons, the court overruled the earlier cases and reversed the trial court's grant of summary judgment in favor of the physician and the hospital.—*Thornton v. Charleston Area Medical Center,* 213 S.E.2d 102 (W.Va.Sup.Ct., of App., Feb. 18, 1975)

Cold/Allergy and Cough Country



Rynatan® Country

RYNATAN, for symptomatic relief of colds and allergic rhinitis. Convenient b.i.d. tablet and liquid dosage.

Rynatuss® Country

RYNATUSS, for symptomatic relief of coughs due to colds and in acute and chronic bronchitis. Convenient b.i.d. tablet and liquid dosage.

Mallinckrodt® Pharmaceuticals *Linking chemistry to medicine®*

Mallinckrodt, Inc. St. Louis, Mo. 63147

RYNATAN®: Each tablet contains Phenylephrine Tannate, 25 mg.; Chlorpheniramine Tannate, 8 mg.; Pyrilamine Tannate, 25 mg.

Each 5 ml. (1 teaspoonful) RYNATAN® PEDIATRIC SUSPENSION contains: Phenylephrine Tannate, 5 mg.; Chlorpheniramine Tannate, 2 mg.; Pyrilamine Tannate, 12.5 mg. CONVENIENT B.I.D. DOSAGE for convenience and economy.

INDICATIONS: RYNATAN provides symptomatic relief of the coryza and nasal congestion associated with the common cold other upper respiratory infections and allergic rhinitis. In sinusitis, drainage from the affected sinuses may be improved.

CONTRAINDICATIONS: RYNATAN is contraindicated in those patients who are sensitive to sympathomimetic drugs.

PRECAUTIONS: Use with caution in patients with hypertension, hyperthyroidism, diabetes or coronary artery disease; warn of possible drowsiness in patients who may operate vehicles or machinery.

ADVERSE REACTIONS: Drowsiness and dryness of the mouth are occasionally associated with antihistamine therapy in some individuals.

DOSAGE AND ADMINISTRATION: RYNATAN TABLETS: 1 or 2 tablets every 12 hours.

RYNATAN PEDIATRIC SUSPENSION: For children over six years of age, 5 to 10 ml. (1 to 2 teaspoonfuls) every 12 hours; for children two to six years of age, 2.5 to 5 ml. (½ to 1 teaspoonful) every 12 hours; for children under two years of age, 1.7 ml. (⅓ teaspoonful) every 12 hours.

CAUTION: Federal (U.S.A.) law prohibits dispensing without prescription.

RYNATUSS®: Each tablet contains Carbetapentane Tannate, 60 mg.; Chlorpheniramine Tannate, 5 mg.; Ephedrine Tannate, 10 mg.; Phenylephrine Tannate, 10 mg.

Each 5 ml. (1 teaspoonful) RYNATUSS® PEDIATRIC SUSPENSION contains Carbetapentane Tannate, 30 mg. Chlorpheniramine Tannate, 4 mg. Ephedrine Tannate, 5 mg.; Phenylephrine Tannate, 5 mg. CONVENIENT B.I.D. DOSAGE for convenience and economy.

INDICATIONS: In the treatment of coughs due to the common cold, asthma, and in acute and chronic bronchitis.

CONTRAINDICATIONS: RYNATUSS is contraindicated in those patients who are sensitive to sympathomimetic drugs.

PRECAUTIONS: Use with caution in patients with hypertension, hyperthyroidism, diabetes or coronary artery disease; warn of possible drowsiness in patients who may operate vehicles or machinery.

ADVERSE REACTIONS: Drowsiness and dryness of the mouth are occasionally associated with antihistamine therapy in some individuals.

DOSAGE AND ADMINISTRATION: RYNATUSS TABLETS: Adults — 1 to 2 tablets every 12 hours.

RYNATUSS PEDIATRIC SUSPENSION: For children over six years of age, 5 to 10 ml. (1 to 2 teaspoonfuls) every 12 hours; for children two to six years of age, 2.5 to 5 ml. (½ to 1 teaspoonful) every 12 hours; for children under two years of age, 1.7 ml. (⅓ teaspoonful) every 12 hours.

CAUTION: Federal (U.S.A.) law prohibits dispensing without prescription.

The above represents a brief summary. See package inserts for full prescribing information.

I AM THE UNITED STATES OF AMERICA

A Bicentennial Message by Alex McKeigney

I am the United States of America—the blessed land of liberty.
I was born a long time ago, because, you see, liberty was born
when God, the Creator, first breathed life into man, created
him in His own image, and breathed into him the spirit of liberty.

I am the dreams, the plans and the work of men and women who have
loved freedom down through all the ages.
I am the first settlers who landed in Virginia and at Plymouth Rock;
I'm the Red man, the Black and Yellow man—I'm millions of people
from all across the earth who came to this good land to live, to
work, to dream, to build—
And to die, if need be, that liberty might still live.

I'm the surging tides of New England, the corn fields of mid-America;
The wheat fields of the plain states; the tall trees of the great West;
I am the cattle grazing on matchless hills and prairies;
I'm the Grand Canyon and painted deserts, the magic of ten thousand
rivers, twisting streams, and sky-blue lakes, large and small.
I'm the cotton fields of Dixie, white sand beaches, mighty oceans and
the moon-lit Gulf;
I'm Rocky Mountain grandeur and limitless treasurers beneath the
earth;
I am country music, opera and symphony, great books and simple rhymes.
I'm mighty industries, financial institutions, busy streets and highways—
Arts and crafts and shops and stores, motion pictures, little
theatre, countless festivals.

I am men and women in field and factory, in laboratories, in
hospitals, in communications media;
Teachers in classrooms; people in professions; men in space, walking on
the moon.
I am an athlete in a crowded stadium or a hunter at early dawn;
I am a minister proclaiming God's Holy Word, and a mighty choir.
I am countless public servants—most of them little known—working
at the many tasks of government all across the land;
Whatever the task—large or small—I'm someone there, carrying the load.

I am the right to free speech, to own property and direct enterprise;
I am the right to worship God, the Creator, and to live life abundantly
in the spirit of Him who gave life eternal.

I answered freedom's call at Lexington and Concord town, prayed
with Washington in the snow at Valley Forge; I was at Yorktown and
New Orleans, in countless battles on the seas, and later in the air;
I fought at the Alamo and Chapultepec, rode with Lee and Jackson,
Stood with Grant at Vicksburg and Meade at Gettysburg; I
charged with the Rough Riders, fought at Belleau Woods, landed
in the hell of Normandy and on a score of Pacific islands—
Stood the test in frozen Korea and steaming Vietnam—
I gave my blood that the blood of others might run free.

I'm all these and much, much more in these United States in this
200th year of liberty;
But more than anything else I am the heart and soul of free men and
women
and little children, who love their God and this good land, and
Who know that in Him there is strength and courage and love to
light the way.
Yes—I am the United States of America—and under God
forever I will be!

Copyright 1975, Alex McKeigney, Jackson, Mississippi

THE LITERATURE

Book Review

Your Second Life. By Harold L. Karpman, M.D., and Sam Locke. 266 pages. Los Angeles: J. P. Tarcher, Inc., 1975. $8.95.

This book could be subtitled *A Layman's Home Guide to Cardiology* as it covers a variety of clinical cardiac situations relating to heart attacks, hypertension, congestive heart failure, angina, palpitations, etc.

It is the combined effort of a cardiologist and a professional playwright and presents much like a Frank Slaughter novel with many verbal illustrations of physiologic mechanisms interspersed throughout the doctor-patient communications. The emphasis is upon teaching the reader the mechanics of the illness at hand, as well as what prophylactic measures can be taken to correct or improve future conditions. This is accomplished in an easily readable and understandable narrative which most patients will probably enjoy and profit from.

Your Second Life is good convalescent reading material and may save the physician precious time in its excellent explanatory dialogues.

HANNELORE GILES, M.D.
Hattiesburg, MS

LETTERS

SIRS: During the week of Dec. 8, approximately 5 per cent of 325 children in one elementary school in Lee County were absent with the mumps. At the time of this writing, surrounding communities have not yet experienced such heavy mumps virus activity.

Mumps is a systemic viral illness with a variety of clinical expressions, the most common of which is parotitis. Fever, headache, and malaise are followed by discomfort, then swelling of the parotid glands. Involvement of one parotid gland commonly precedes the other by 2-5 days. Twenty-five per cent of cases have unilateral involvement. Symptoms usually subside within 7-10 days. While parotitis is the most common clinical expression of illness, other glandular tissues, especially the submaxillary and sublingual salivary glands, are frequently involved. Some 30-40 per cent of infections are asymptomatic.

Orchitis in post-pubertal males is unilateral in 20 per cent and bilateral in about 4 per cent. Orchitis is extremely painful, but the common concerns about sterility and impotence are highly exaggerated. Physiologic impotence does not occur because the infection involves the tubules and not the Leydig cells. Sterility is extremely uncommon (exact incidence unknown) even though variable degrees of testicular atrophy of the involved testis is common.

Meningoencephalitis, characterized by fever, headache, nausea, vomiting, nuchal rigidity, and abnormal sensorium occurs in 10 per cent of patients. Sequelae are uncommon. Other CNS complications such as unilateral deafness, facial neuritis, and myelitis are less common.

The differential diagnosis of mumps parotitis includes the relatively common cervical adenitis and a variety of less common disorders such as idiopathic recurrent parotitis, uveoparotid fever (sarcoidosis), Mickulicz's syndrome, tumors, and others. Mumps meningoencephalitis without parotitis cannot be distinguished clinically from meningoencephalitis of other etiologies and requires acute and convalescent serology (available through the State Board of Health) for an exact diagnosis.

Mumps usually occurs in the winter and spring in children between 5-10 years old. Eighty-five per cent of persons are infected by age 15. Man is the only known reservoir for the virus. Infection is spread by direct contact with saliva or secretions of an infected person. The usual incubation period is 18 days. Virus has been recovered from saliva from 6 days before to 9 days after onset of parotitis. Persons are most infectious about 24 hours before symptoms begin. Persons with asymptomatic infections are infectious.

Treatment is symptomatic. The isolation of patients known to be infected is commonly recommended, but probably does not prevent spread of disease because (1) the period of greatest communicability usually precedes symptoms and (2) persons with asymptomatic infections shed virus. The live attenuated virus vaccine is highly effective

(95 per cent) when given before exposure. Post exposure vaccination has not been shown to be effective. The vaccine has no known major side effects although prudence precludes its use in pregnant women. The vaccine may be given alone or in combination with the measles and rubella vaccines.

The management of the exposed, concerned adult male who does not recall a childhood infection is a common problem. Assuming 35 per cent asymptomatic infections and 85 per cent infected by age 15; at age 15, 55 per cent of men will have had symptomatic, 30 per cent asymptomatic, and 15 per cent no infection. The proportion not previously infected declines even further with age. Therefore, most men have been infected even if they can't remember it. Serological techniques can be used to establish previous infection, but generally require several days. Hyperimmune globulin is not effective and post exposure vaccination has not been shown to be effective or ineffective. Given the safety of the vaccine and the as yet unsubstantiated hope that it may be effective if given within a few days of exposure. Some physicians elect to administer the mumps vaccine to the overly anxious adult male.

The Bureau of Disease Control encourages you to report cases of mumps and other reportable diseases to your local health department or directly to our bureau.

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health

DEATHS

McKINNON, JOSEPH G., Hattiesburg. Born Hattiesburg, MS Nov. 8, 1911; M.D., University of Tennessee College of Medicine, Memphis, TN, 1935; interned, one year, University Hospital, Columbus, Ohio; surgery residency, University Hospital, Columbus, Ohio, and Vicksburg Hospital, Vicksburg, MS.; died Nov. 30, 1975, age 64.

PRESCRIBING INFORMATION
Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

NSN 6505-00-148-6967

Pinworms, roundworms controlled with a single, non-staining dose of

ANTIMINTH®

(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

*Data on file at Roerig.

Please see prescribing information on facing page.

NEW MEMBERS

COLLUM, JULIUS, Jackson. Born Jackson, MS, July 9, 1938; M.D., University of Mississippi School of Medicine, Jackson, 1965; interned, same, one year; child psychiatry residency, Emory University Hospital, Atlanta, GA, 1966-70; elected by Central Medical Society.

KUSHNER, SHELDON R., Meridian. Born Montgomery, AL, Jan. 31, 1942; M.D., University of Alabama Medical College, Birmingham, 1966; interned University Hospital, Birmingham, AL, one year; residency in ob-gyn, Cincinnati General Hospital, Cincinnati, Ohio, 1969-72; elected by East Mississippi Medical Society.

MCCLUNG, LAWSON E., Tunica. Born Memphis, TN, Sept. 16, 1942; M.D., University of Tennessee College of Medicine, Memphis, 1967; interned University Hospital, Augusta, GA, one year; elected by Clarksdale & Six Counties Medical Society.

MORRISON, MARGARET H., Meridian. Born Sewanee, TN, April 23, 1933; M.D., University of Tennessee School of Medicine, Memphis, 1959; interned St. Louis City Hospital, St. Louis, MO, one year; pediatric residency, John Gaston Hospital, Memphis, TN, 1961-64; pediatric neurology fellowship, same; elected by East Mississippi Medical Society.

NICHOLS, FRANK A., Tupelo. Born Washington, DC, April 7, 1942; M.D., University of Chicago School of Medicine, Chicago, IL, 1968; interned University of Rochester, NY, one year; general and vascular surgery residency, same, 1969-73; fellowship, cardiothoracic surgery, same, 1973-75; elected by Northeast Mississippi Medical Society.

PIERCE, PAUL W., III, Vicksburg. Born Oxford, MS, Jan. 19, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned, same, one year; internal medicine residency, same, 1972-75; elected by West Mississippi Medical Society.

SHOWS, BILLY RAY, Newton. Born Dec. 7, 1940; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned Mississippi Baptist Hospital, Jackson, one year; elected by East Mississippi Medical Society.

WHELOCK, MARK C., Jackson. Born Sioux City, Iowa, June 14, 1905; M.D., University of Iowa College of Homeopathic Medicine, Iowa City, Iowa, 1930; interned Western Pennsylvania Hospital, Pittsburgh, PA, one year; pathology residency, University Hospital, Cleveland, Ohio, one year; pathology residency, Metro General, Cleveland, Ohio, 1938-40; elected by Central Medical Society.

WILKINSON, CHARLES L., Meridian. Born Memphis, TN, June 10, 1941; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned Mississippi Baptist Hospital, Jackson, one year; pathology residency, Baptist Memorial Hospital, Memphis, TN, 1970-74; elected by East Mississippi Medical Society.

WILLIAMS, MORRIS E., Jackson. Born Henderson, NC, Jan. 25, 1942; M.D., University of North Carolina School of Medicine, Chapel Hill, 1968; interned University of Alabama Hospital, Birmingham, AL, one year; internal medicine, residency, same, 1969-73; fellowship in cardiology, same, 1973-75; elected by Central Medical Society.

PERSONALS

JACK A. ATKINSON of Brookhaven, MSMA president, addressed the Brookhaven Kiwanis Club meeting in December.

ROBERT NEIL BAKER announces the opening of his practice of general medicine at the Gulf Coast Surgical and Diagnostic Center, P.A., Medical Plaza, Vancleave Road in Ocean Springs.

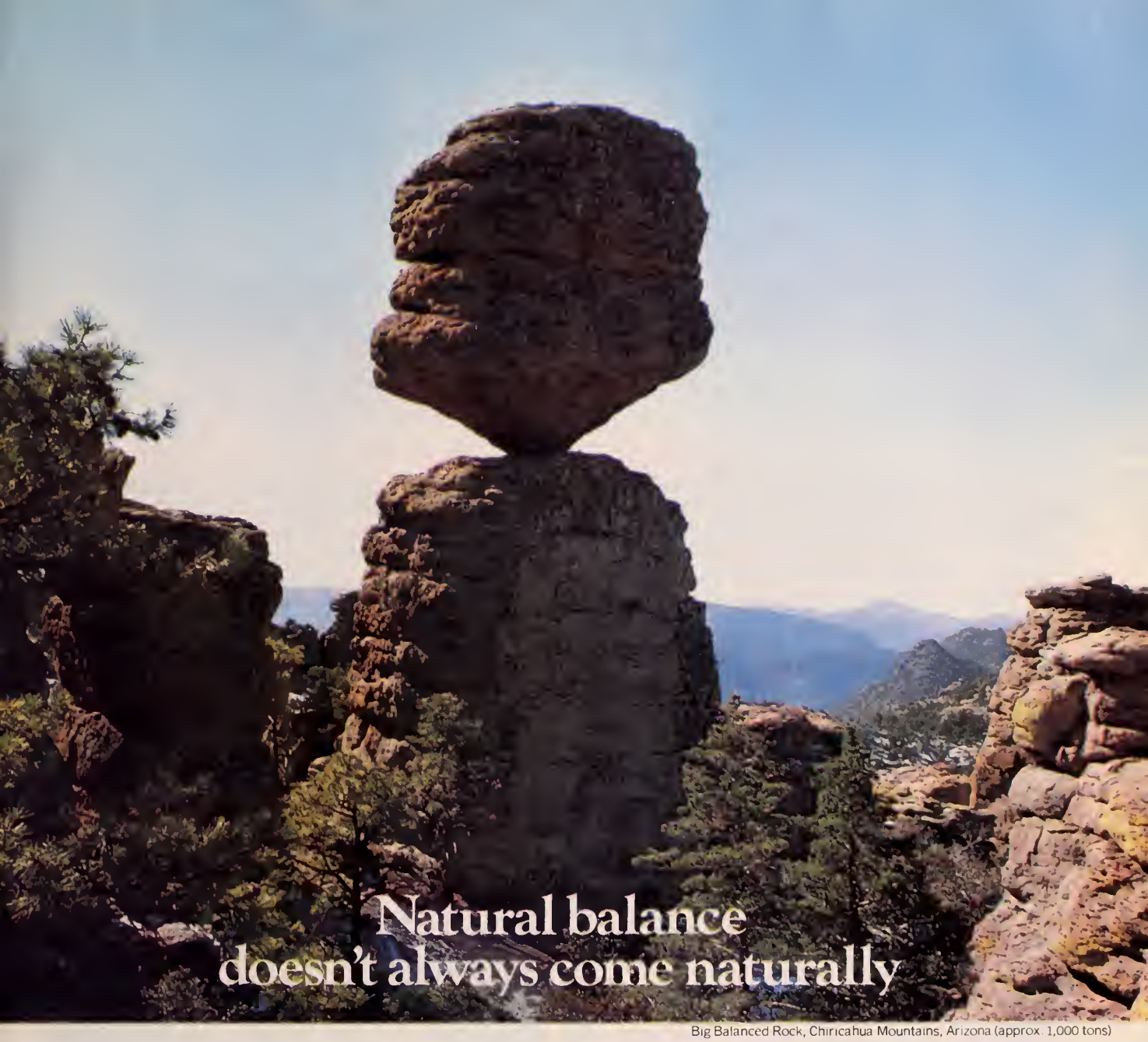
AUSTIN P. BOGGAN of Decatur is new president of the East Mississippi Medical Society. Other officers are: JAMES A. LAUDERDALE, JR., of Meridian, president-elect; and GEORGE L. ARRINGTON, JR., of Meridian, secretary.

JOHN D. BOWER and GEORGE V. SMITH of Jackson and UMC participated in an End Stage Renal Disease meeting held in Memphis.

JAMES A. BRUCE, formerly of Memphis, has associated with JAMES W. RAYNER of Oxford at the Rogers Clinic for the practice of ophthalmology.

DUANE BURGESS of Hattiesburg is serving as president of the Hub City Kiwanis Club.

GUY CAMPBELL, JOE R. NORMAN, KENNETH R. BENNETT, A. WALLACE CONERLY, G. BOYD SHAW, and JOHN D. MORGAN were UMC participants in a blood gas workshop held in Jackson.



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

□ Found useful in the management of vertigo* associated with diseases affecting the vestibular system.
□ Can relieve nausea and vomiting often associated with vertigo.*
□ Usual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.
□ Also available as Antivert (meclizine HCl) 12.5 mg. scored tablets, for dosage convenience and flexibility.
□ Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for nausea, vomiting and dizziness associated with motion sickness.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

INDOCIN®
(INDOMETHACIN | MSD)



helps relieve pain
and other symptoms
of inflammation
in acute
gouty arthritis
in selected patients

IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended. The drug should not be prescribed for children because safe conditions for use have not been established.

Because of the high potency of the drug and the variability of its potential to cause adverse reactions, the following are strongly recommended: 1) the lowest possible effective dose for the individual patient should be prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg per day, without corresponding clinical benefits; 2) careful instructions to, and observations of, the individual patient are essential to the prevention of serious and irreversible, including fatal, adverse reactions, especially in the aging patient.

Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin or indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.

Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.

Central Nervous System Effects: INDOCIN may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS adverse reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; rarely, intestinal ulceration has been associated with stenosis and obstruction; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis, which may persist after the cessation of the drug; nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.

Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.

Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.

Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.

Hypersensitivity Reactions: Acute respiratory distress, including dyspnea and asthma; angiitis; pruritus; urticaria; angioedema; skin rashes; purpura.

Ear Reactions: Hearing disturbances, deafness, tinnitus.

Central Nervous System Reactions: Psychic disturbances including psychotic episodes, depersonalization, depression, and mental confusion; coma; convulsions; peripheral neuropathy; drowsiness; lightheadedness; dizziness; syncope; headache.

Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.

Dermatologic Reactions: Loss of hair, erythema nodosum.

Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.

Note: In patients receiving probenecid, plasma levels of indomethacin are likely to be increased.

Supplied: Capsules containing 25 mg indomethacin each, in single-unit packages of 100 and bottles of 100 and 1000; capsules containing 50 mg indomethacin each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

MSD
MERCK
SHARP &
DOHME

ROBERT D. CURRIER of Jackson and UMC is new president of the History of Medicine Society. He succeeds JOHN Y. GIBSON.

New officers of the Pearl River County Medical Society are: president, J. C. GRIFFING of Picayune, and secretary, SEWALL KEPNER of Picayune.

HARRY BRAD HEITZMAN announces the relocation of his office for the practice of internal medicine to the Gulf Coast Surgical and Diagnostic Center, P.A., Medical Plaza, Vancleave Road, Ocean Springs.

JACK HOOVER of Pascagoula has been named chairman of the Military Affairs Committee of the Pascagoula-Moss Point Area Chamber of Commerce.

JACK KING of Jackson announces the reopening of his office for the practice of colon and rectal surgery on Jan. 15 at 504 Medical Arts Building.

RUSSELL RAY LYLE of Starkville has been elected to fellowship in the American Academy of Pediatrics.

MAURY MCRAE of Corinth was honored by the community with Maury McRae Day on Nov. 25. He was cited for years of outstanding medical services rendered to the people of the area.

SHANTI PANDEY of Fayette announces the relocation of her office to The Arbind Clinic, on Hwy 61 South across from Jefferson County Hospital.

JOE R. NORMAN of Jackson and UMC spoke on "high-dose methylprednisolone sodium succinate in status asthmaticus" at a December Baptist Medical Center conference in Birmingham.

H. M. LEE and T. N. BRADDOCK of West Point have been selected to serve on an advisory council designed to assist the Regional Mental Health Complex in planning mental health and retardation services for Clay County.

LEO J. SCANLON of Vicksburg is new president of the Vicksburg Kiwanis Club.

EDWARD G. SCOTT of Meridian attended a seminar on cardiovascular diseases, held recently in Point Clear, Ala.

DONALD M. SHERLINE of Jackson and UMC attended a preplanning committee meeting of the National Family Planning Association for World Obstetrics in Sioux Falls, S.D.

W. C. SIMMONS of Bay Springs has been honored by the Jasper General Hospital board and medical staff. He was presented a plaque in recognition of his 47 years of dedicated service to the citizens of Jasper County and for his support of the hospital.

TOMMY T. SIMPSON of Ripley is new president of the North Mississippi Medical Society. CHERIE FRIEDMAN of Oxford was re-elected secretary.

ROBERT D. SLOAN of Jackson and UMC was a guest examiner for the American Board of Radiology in Dallas during December.

HOWELL TOWLER and WILLIAM HARRISON have set up practice at the Doctor's Park in Houston. Dr. Towler is an ear, nose and throat specialist and Dr. Harrison is a pediatrician.

POSTGRADUATE CALENDAR

Feb. 23-25, 1976

UROLOGY INTENSIVE COURSE

University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center, Division of Continuing Health Professional Education with partial support from Mississippi Regional Medical Program

Coordinator:

W. Lamar Weems, M.D., professor of surgery (urology) and chief of the division of urology, the University of Mississippi School of Medicine

This course is structured to give the primary physician an overview of current methods of diagnosing and treating common urological diseases. Topics to be covered include urinary tract infections, benign prostatic hyperplasia, cancer of the prostate, kidney and testicles, stones, septicemia, urethral strictures, trauma, infertility and impotence, catheter care, and the neurogenic bladder.

Mar. 3-5, 1976

OTOLARYNGOLOGY INTENSIVE COURSE

University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center, Division of Continuing Health Professional Education with partial support from Mississippi Regional Medical Program

Coordinator:

Godfrey E. Arnold, M.D., professor of surgery and director of the division of otolaryngology, the University of Mississippi School of Medicine

This three-day course will present basic otolaryngology as needed by the primary care physician. Lecture topics will include ENT anatomy, dizziness and vertigo, oro-facial infections, oral cavity lesions, laryngeal paralysis, pathology, head and neck tumors, salivary glands, laryngeal disease, maxillofacial trauma, genetics of speech and hearing problems, genetic syndromes of head and neck, sinus disease, otitis externa and media, pediatric and adult speech and language disorders, epistaxis, surgical procedures, and otogenic complications. Registrants will attend grand rounds.

Mar. 11-13, 1976

Surgical Forum III

Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine, Department of Surgery and the University Medical Center Division of Continuing Health Professional Education

Coordinators:

James D. Hardy, M.D., professor of surgery and chairman of the department, the University of Mississippi School of Medicine

William O. Barnett, M.D., professor of surgery, the University of Mississippi School of Medicine

An internationally known faculty will lecture and answer questions on topics of interest to the general surgeon. The three-day annual event focuses on vascular, general, stomach, and biliary tract surgical techniques. Attendance is by invitation, and advance registration is required.

Mar. 18-20, 1976

Neurology/Neurosurgery Intensive Course

University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center, Division of Continuing Health Professional Education with partial support from Mississippi Regional Medical Program

Coordinators:

Robert D. Currier, M.D., professor of medicine and chief of the division of neurology, the University of Mississippi School of Medicine

Glen C. Warren, M.D., clinical assistant professor of neurosurgery, the University of Mississippi School of Medicine

This course will deal with the problems primary care physicians encounter most often in their practices. Participants will discuss head injury, the dizzy patient, headaches, epilepsy, sciatica, strokes, and tumors in relation to adult and pediatric neurology and neurosurgery.

Mar. 22-26, 1976

Pediatrics Intensive Course

University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center, Division of Continuing Health Professional Education with partial support from Mississippi Regional Medical Program

Coordinator:

J. M. Montalvo, M.D., professor of pediatrics, the University of Mississippi School of Medicine

Course content includes special problems in newborn care; neurology, with a special emphasis on convulsive seizures, meningitis, and head trauma; care and problems of the adolescent; allergy; hematology; oncology; pediatric emergencies; cardiology; radiology; fluid and electrolytes; nephrology; endocrinology; inhalation therapy; pediatric surgery; and orthopedic problems in children.

FUTURE CALENDAR

April 5-9, 1976
Pulmonary Medicine Intensive Course

April 13
Mississippi Thoracic Society Meeting

April 19-23
Nephrology Intensive Course

April 27-28
Emergency Care Course

April 30
Annual Kidney Disease Seminar

May 3-6
Mississippi State Medical Association, Jackson

The University of Mississippi Medical Center Division of Continuing Health Professional Education offers intensive refresher courses to meet physicians' clinical practice needs in the specialties most requested. Mississippi Regional Medical Program partially supports the series, open to all physicians.

New State Administration Begins

A new state administration began last month with the convening of the 1976-1980 Mississippi Legislature and inauguration of the state's 57th governor and other state elected officials to include the first female Lt. Governor in the state's history.

Organization of the state legislature contained few surprises. Representative Buddy Newman was elected speaker of the House of Representatives without opposition and replaced several former committee chairmen who reportedly had not vigorously supported the new speaker in his past campaigns for the House's highest office. Lt. Governor Gandy, after many days of rumors that several former senate committee chairmen would be replaced, proceeded to re-appoint most chairmen. Senator Bill Alexander of Cleveland was elected President "Pro Tempore" of the Senate without opposition.

With few exceptions most committee chairmen came from the Delta and "Hills" sections of the state and this prompted several central and south Mississippi legislators to criticize the new speaker and Lt. Governor for failing to recognize the state's most populated areas in designating committee chairmen.

Governor Charles Clifton Finch, "the working man's candidate," stressed hard work, cooperation, efficiency in state government and economic development in his inaugural address and unlike his predecessor, appeared to strive to begin his administration on friendly terms with the Legislature.

Reapportionment and money will be this Legislature's most pressing problems. The former will either be decided by a federal court or the Legislature and predictions are that quite a number of legislators will be running for office again next year in new, court designated districts. Mississippi's money problems are a result of the national economy, and many proposals for new and expanded state programs are expected to die in Legislative committees because of a decline in state revenues.

The 172 member legislature contains 67 new representatives and senators and observers believe that this is a "better quality legislature" than those in the past. Once again attorneys are the most prevalent profession in the legislature.

Aside from health appropriations and professional liability legislation, most health matters will again be in the hands of the House and Senate public health committees which will be chaired by Representative G. Milton Case of Canton and Senator Theo Smith of Corinth. Most of MSMA's proposed professional liability legislation is expected to be assigned to Judiciary Committees of the two houses. Appropriation bills will be assigned to committees chaired by Senator Bill Burgin of Columbus and Representative Charles Deaton of Greenwood.

Health bills, some old, some new, began to be introduced soon after committees were named. Some of the old bills, such as those to reorganize the State Board of Health, to permit optometrists to place drugs on the eye, and to regulate physicians' assistants are expected to again stir up considerable

controversy. New bills cover such subjects as permitting pharmacists to substitute drugs and designating the Governor's Office of Comprehensive Health Planning as the new State Planning and Development Agency under requirements of Public Law 92-641, the National Health Planning and Resources Development Act of 1974.

Members of the House and Senate Public Health Committees are: (House) G. Milton Case, chairman, Canton; Don W. Richardson, vice chairman, Jackson; Douglas Anderson, Jackson; R. G. Anderson, Jackson; C. Ashley Atkinson, McComb; William W. Canon, Columbus; Richard O. Clark, Pickens; J. P. Compretta, Bay St. Louis; James D. Disharoon, Crystal Springs; Dennis E. Dollar, Gulfport; T. A. Gollott, Biloxi; Carl J. Gordon, Okolona; Mack Graham, Sumrall; William L. Grist, Vardaman; John D. Haynes, Baldwyn; B. W. Hollingsworth, Morton; Clifton Holmes, Foxworth; Robert G. Huggins, Greenwood; Charles J. Lippian, Pascagoula; Frank Lynn, Moss Point; Wesley A. McIngvale, Batesville; Mack McInnis, Leakesville; Harold Montgomery, Tupelo; James D. Nunnally, Ripley; J. W. Raney, Jackson; Harold Stringer, Prentiss; and Jerry Wilburn, Mantachie; (Senate) Theodore Smith, III, chairman, Corinth; Nap L. Cassibry, II, vice chairman, Gulfport; Tommy N. Brooks, Carthage; Dale H. Ford, Taylorsville; James E. Molpus, Clarksdale; Ray H. Montgomery, Canton; Joe Henry Hulholland, Philadelphia; James E. "Jim" Noblin, Jackson; Edgar H. Overstreet, Oxford; Perrin H. Purvis, Tupelo; I. S. "Ike" Sanford, Collins; Emerson Stringer, Columbia; and Sam W. Wright, Clinton.

State Medical Institutions Face Cuts

The state's charity hospitals and the University of Mississippi School of Medicine will face serious operating problems if cuts in funding for the institutions proposed by the State Budget Commission are approved by the 1976 Mississippi Legislature.

The Budget Commission has recommended cuts in funding for the charity hospitals and the University Hospital ranging from 14 to 67 per cent of current funding levels.

The commission, which is composed of key legislative leaders, annually reviews and recommends budgets for all state agencies for final action by the Legislature.

In its budget report to the 1976 Regular Session of the Mississippi Legislature, the commission recommended that operating funds for the University Hospital and the state's five charity hospitals be cut from current funding levels of $8.5 and $11.7 million to $7.2 and $9.6 million in fiscal year 1977.

The recommended cutbacks at each institution are:

—$315,240 or 67.3 per cent, from Matty Hersee Hospital in Meridian.

—$288,498 or 23.9 per cent, from Kuhn Memorial in Vicksburg.

—$114,287 or 17.7 per cent, from South Mississippi Hospital in Laurel.

—$98,077 or 14 per cent, from Natchez Charity Hospital in Natchez.

—$1.3 million, or 15.4 per cent, from University Hospital in Jackson.

Physicians/Clergy Workshop Held at UMC



"The secret in the care of a patient is in caring for the patient," Batesville physician Dr. David Ball, second right, told physicians and clergymen at a University of Mississippi Medical Center workshop. Other program participants who explored the potential for complementary health care delivery were, from left, Dr. W. Jackson Wilson, rector at Christ Episcopal Church, South Pittsburg, TN; Dr. Samuel Southard, deputy superintendent of manpower and training, Georgia Mental Health Institute, Atlanta; Dr. Ball; and Dr. James L. Travis, University Hospital director of pastoral services and chaplain. The Mississippi Religious Leadership Conference cosponsored the event with the UMC Department of Pastoral Services.

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

FOR LONG-TERM CONTROL OF HYPERTENSION*

Serum K^+ and BUN should be checked periodically. (See Warnings Section.)



Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Warning**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

***Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F Co., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

Effectiveness across the spectrum of most common forms of insomnia

Awake too long, awake too often, awake too early...

These are the most common forms of insomnia, and may occur singly or in any combination. The night of troubled sleep depicted here comprises all three types. As the night progresses from left to right, each sleep stage is identifiable by its own shade of gray. Blue represents "Awake."

As you can see, this hypothetical "patient" takes well over an hour to fall asleep, awakens several times during the middle of the night and awakens too early in the morning.

Sleep Stages

- Awake
- REM
- Stage 1
- Stage 2
- Stage 3
- Stage 4



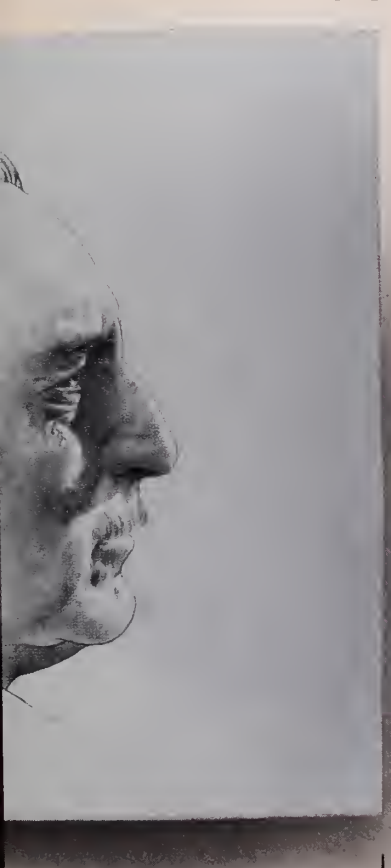
The insomnias most often occurring in young and older adults

For patients with trouble falling asleep (common in young adult insomnia patients), Dalmane (flurazepam HCl) 30 mg provides sleep within 17 minutes, on average. For those with trouble staying asleep or sleeping long enough (common in those over 50), Dalmane offers increased total sleep time with fewer nocturnal awakenings. These clinical results were demonstrated in studies conducted in four geographically separated sleep research laboratories[1-4]

The relative safety of Dalmane (flurazepam HCl) is well documented

Dalmane (flurazepam HCl) is relatively safe and well tolerated; morning "hang-over" has been infrequent. The usual adult dosage is 30 mg; in elderly or debilitated patients, limit initial dosage to 15 mg to preclude over-sedation, dizziness or ataxia. Caution patients about possible combined effects with alcohol and other CNS depressants.

Broad-spectrum medication for the most common forms of insomnia



Awake too early



Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.

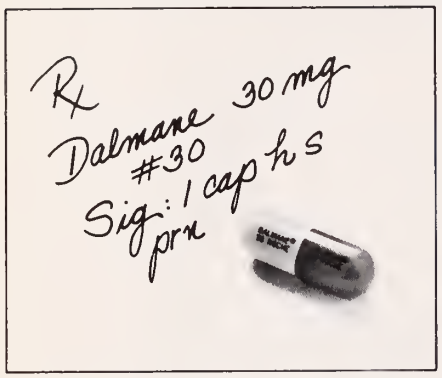
- ☐ induces sleep rapidly
- ☐ reduces nighttime awakenings
- ☐ lengthens total sleep time

ROCHE

Please see following page for a summary of complete product information.

Broad-spectrum medication for the most common forms of insomnia

Dalmane®
(flurazepam HCl) ℞ IV



Objectively proved in the sleep research laboratory, Dalmane

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- provides 7 to 8 hours sleep, on average, without repeating dosage

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES:

1. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
2. Frost JD Jr: A system for automatically analyzing sleep. Scientific exhibit at the 24th Clinical Convention of the American Medical Association, Boston, Nov 29-Dec 2, 1970; and at the 42nd annual scientific meeting of the Aerospace Medical Association, Houston, Apr 26-29, 1971
3. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
4. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ



ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

MSMA Conducts Physicians' CME Survey

The MSMA Council on Medical Education is conducting a survey of physicians' continuing medical education programs in Mississippi which will lead to annual publication of a "CME Directory for Mississippi Physicians."

The council is surveying all hospitals, medical specialty societies and appropriate voluntary health agencies in the state with a view toward finding out what CME programs are presently offered and assisting interested organizations in establishing accredited CME programs for physicians.

MSMA and its Council on Medical Education received recognition from the American Medical Association in 1973 as an accrediting body for institutions and organizations providing intrastate continuing medical education programs.

Family Medicine Preceptorship Funded

A training grant to the University of Mississippi Medical Center may help interest future physicians in practicing where they're most needed: in Mississippi.

The DHEW Public Health Service award to the Department of Family Medicine at the Medical Center will strengthen and expand a three-week community training program or preceptorship for medical students. It will also increase continuing education opportunities for Mississippi's family physicians.

The $317,065 grant will be spread over a three-year period. First year funds total $94,834.

The Mississippi medical school established the Department of Family Medicine in 1973 as one effort to answer the state's acute need for primary care physicians. Since then, senior medical students have chosen preceptorships with practicing family physicians in Jackson or other Mississippi locations. With the physician-teachers, the students learn about continuous and comprehensive family-centered care on a local level.

Nearly 100 students have participated in the program, with 40 of those already signed up for the current year. They're among the more than 60 per cent of this year's senior class who have indicated an interest in primary practice.

In June, the three-week preceptorship training will become a requirement for all junior medical students. Seniors may take an additional preceptorship for further exposure to family medicine.

The DHEW grant will provide small stipends to the students and fund family medicine department workshops to help prepare and qualify the preceptors for their teaching roles. Twenty-five family physicians qualified as preceptors in the first workshop in 1974. Nine additional workshops are planned for early 1976.

Preceptor workshop dates and sites are Feb. 4, Greenwood; Feb. 25, Laurel; Mar. 10, Oxford; Mar. 24, Natchez; April 8, Greenville; April 21, Biloxi; April 29, Meridian; May 6 (tentative), Starkville; and May 13, Gulfport.

"We're getting medical students into all areas of the state," said Dr. Hardy Woodbridge, assistant professor of family medicine and program coordinator. "We hope the experience will encourage them to go back after residency training to practice in similar locales, where doctors are in short supply."

That can, he emphasized, mean improved health care for many Mississippians.

Emergency Medical Care Unit Opens at Capitol

The MSMA Emergency Medical Care Unit in the Capitol Building at Jackson opened Jan. 6, 1976, for the twelfth consecutive year of service during the 1976 Regular Session of the Legislature.

The association's public service project is again staffed by Mavis Barlow, R.N., of Florence. Physician's services are provided by volunteer Doctors of the Day.

Response by the MSMA membership to DOD assignment requests has been excellent, according to Dr. Charles R. Jenkins of Laurel, chairman of the Council on Legislation.

Legislative leaders have praised the service which costs the state nothing. Physicians contribute their services, and association funds are used to defray direct expenses. Some pharmaceutical firms donate supplies and drugs, and the state furnishes the unit space, a telephone, utilities and janitorial services.

Mrs. Barlow said the unit's practice is brisk. Conditions seen in previous years ranged from the common cold to heart attacks.

New SBH Appointees Are Announced

In one of his last official acts, Governor William L. Waller named the following physicians to fill vacancies on the Mississippi State Board of Health which occurred on Jan. 1, 1976: Drs. James O. Gilmore, Oxford, Public Health District 2; William B. Hunt, Grenada, Public Health District 4; and Frank W. Bowen, Carthage, Public Health District 5.

Terms of office on the MSBH are for six years and three nominees for each vacancy on the Board are selected by the MSMA House of Delegates for appointment of one by the governor. Appointees are then subject to confirmation by the Mississippi Senate.

The MSBH administers a broad range of public health and health related programs and has an annual budget of $21 million.

Postgraduate Course on the Spine Set

An interspecialty postgraduate seminar regarding the spine will be presented in Phoenix, April 12-14, 1976. Guest faculty includes orthopedic surgeons and radiologists.

The course is approved for 15 hours of Category I credit by the American Medical Association. Tuition is $110.00.

For further information write to program director, Dr. Austin R. Sandrock, Department of Radiology, Maricopa County General Hospital, 2601 E. Roosevelt, Phoenix, Arizona 85008.

Dr. Harmon Smith Speaks at Millsaps

Dr. Harmon L. Smith Jr., professor of moral theology and professor of community health sciences, a joint appointment on the medical and divinity faculties at Duke University in Durham, NC, will speak on "Managing the Manner and Time of Human Dying and Death" at Millsaps College in Jackson on Friday, Feb. 27.

Dr. Smith, a 1952 alumnus of Millsaps, will speak at 12:30 p.m. in Room 215 of the Academic Complex as part of the "Friday Forum" series. The public is invited.

He has lectured at more than 50 colleges and universities and in more than 25 medical schools and hospitals in America and in Europe. In 1973 he was the Humanities Research Fellow in the Department of Neurologic Surgery at St. Barnabas Hospital, Bronx, NY. Currently, he is U. S. Regional Educator of the journal "Science, Medicine and Man."

Dr. Smith holds membership on the ethics committee of the American Heart Association and is an affiliate medical staff member of the St. Barnabas Hospital Department of Neurosurgery. He is a contributor to religious, scientific and medical publications. One of his best known publications is "Ethics and the New Medicine."

He received his Ph.D. degree from Duke.

MSMA Reviews Medicaid Practices

In a recent statement to all Mississippi news media, MSMA president, Dr. Jack A. Atkinson, reported that "the association's Committee on Peer Review was reviewing the practices of all physicians in the state receiving more than $100,000 annually in Medicaid payments and had thus far found that the cost, quality and necessity of medical services provided by the physicians met all professional standards of good practice."

"These physicians practice in areas where the Medicaid population is 26 per cent of the total population or almost double the state average," Dr. Atkinson continued, "and there is one physician per 2,400 persons compared to a national average of one physician per 781 persons."

"The physicians are practicing between 65-112 hours a week compared to a Southeastern U.S. average of 50 hours a week and are seeing 75-130 patients a day. When gross income to these physicians, which is what Medicaid reports, is balanced against practice expenses to handle this volume of patients and hours devoted to practice, it is apparent that gross income is a poor indication of the cost, quality and necessity of medical services," Dr. Atkinson concluded.

JOIN MPAC TODAY

PRINTING — OFFICE SUPPLIES

EQUIPMENT — FURNITURE



Premier Printing Company

2485 West Capitol Jackson, Mississippi

Phone 352-4091

Index to Advertisers

Adolescent Care Unit 17

Blue Cross-Blue Shield of MS 12
Burroughs Wellcome Co. 10B

Canton Exchange Bank 11

Dow Pharmaceuticals 38A, 38B, 38C, 38D

Hill Crest Hospital 15
Hyrex-Key Pharmaceuticals 16

Eli Lilly and Co. ..... front cover

Mallinckrodt, Inc. 14B, 14C, 50A
Mead Johnson Labs 8

Merck Sharp and Dohme 54B, 54C, 54D

Pharmaceutical Manufacturers Assoc. 6, 7
Premier Printing Co. 19

A. H. Robins Co. 46A, 46B, 47
Roche Laboratories
.. second cover, 3, 58B, 58C, 58D, third cover, fourth cover
Roerig, A Division of Pfizer Pharmaceuticals .. 52, 53, 54A

Smith Kline and French 58A
Systemedics/AMS of Southern MS 4

Warner Chilcott Laboratories 10, 10A
Wayne Medical Laboratory, Inc. 14

Thomas Yates and Co. 18

IN CONCLUSION

A greater emphasis on the search for environmental causes of cancer was urged by Philippe Shubik, M.D., director, Cancer Research Institute, University of Nebraska. He said the National Cancer Institute is testing about 500 commonly used chemicals for carcinogenicity, but it might be necessary to test 1,500 sometime in the foreseeable future. He also cited the need to double the number of NCI scientists to study adequately cancer prevalence, geographic distribution, and other factors affecting occurrence.

The University of Rochester Medical School has trained 10 barbers to provide advice on where to go for help with health problems in eight two-hour sessions on such subjects as hypertension, venereal disease, dermatology, alcoholism and family problems. "Often in the course of talking with his clients, a barber is privy to personal information sometimes centering around health or family problems," said D. J. Ciaglia, M.D., department of preventive medicine and community health. Now they can more accurately inform clients, he added.

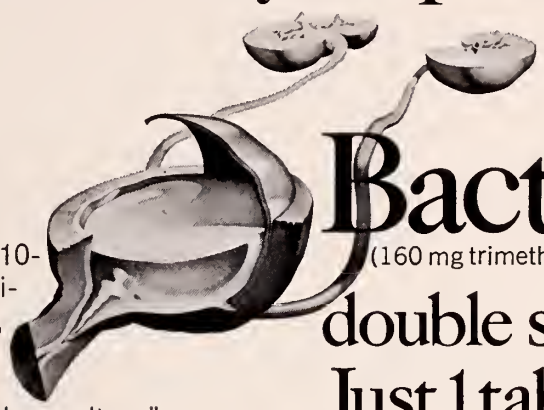
LIBRARY
FEB 1 1 1976
NEW YORK ACADEMY
OF MEDICINE

The first nationwide child abuse study shows that more than a million American children suffer physical abuse or neglect each year, and at least one in five victims dies from the mistreatment. Gathered for HEW by the American Humane Association, the statistics were made available by the National Center on Child Abuse and Neglect in a New York Times interview. Figures were based on reports from 30 states involving more than 311,000 children. With more accurate reporting, it is estimated that about one million cases would be reported annually.

The National High Blood Pressure Education Program has made substantial progress toward its goal of alerting the medical community and general public to the high prevalence of hypertension in the U.S., dangers of uncontrolled hypertension, and health benefits of adequate blood pressure control, announced HEW. Data indicate that there have been sharp increases in initial and total patient visits to physicians for hypertensive heart disease; a sharp reduction in the cases of unsuspected and undiagnosed hypertension; and increase in the number of patients whose blood pressure is under control.

A new 134-page booklet, "Nutrition Labeling - How It Can Work For You," has been developed by the National Nutrition Consortium. The book contains a basic primer on all the nutrients and a lay-language discussion on coordinating this basic information with the information on nutrition labels, for use in menu selection and meal planning. Special conditions, such as pregnancy, low-cholestrol regimes, old age, and childhood are covered. Copies can be ordered for $2.00 per copy form Nutrition Labeling, P. O. Box 4110, Kankakee, IL 60901.

10-day Bactrim therapy outperforms 10-day ampicillin therapy.



In a multicenter, double-blind study of patients with chronic or frequently recurrent urinary tract infection, Bactrim 10-day therapy outperformed ampicillin 10-day therapy by 27.2%, when comparing patients who maintained clear cultures for eight weeks. Criterion for "clear culture" was 1000 or fewer organisms/ml of urine.

While adverse reactions were mild (*e.g.*, nausea, rash), more serious reactions can occur with these drugs. See manufacturers' product information for complete listing.

Note: Bactrim single strength tablets were used in these clinical trials. However, studies have established the bioequivalency of Bactrim DS with the single strength tablets.

Bactrim™ T.M. DS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

double strength tablets Just 1 tablet B.I.D.

Bactrim™ T.M.

(80 mg trimethoprim and 400 mg sulfamethoxazole)

2 tablets B.I.D.

For chronic or frequently recurrent cystitis and pyelonephritis due to susceptible organisms.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections evidenced by persistent bacteriuria (symptomatic or asymptomatic), frequently recurrent infections (relapse or reinfection), or infections associated with urinary tract complications, such as obstruction. Primarily for cystitis, pyelonephritis or pyelitis due to susceptible strains of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris* and *Proteus morganii.*

NOTE: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. **Data are insufficient to recommend use in infants and children under 12.**

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) every 24 hours
Below 15	Use not recommended

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole — bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; fruit-licorice flavored — bottles of 16 oz (1 pint).

ROCHE

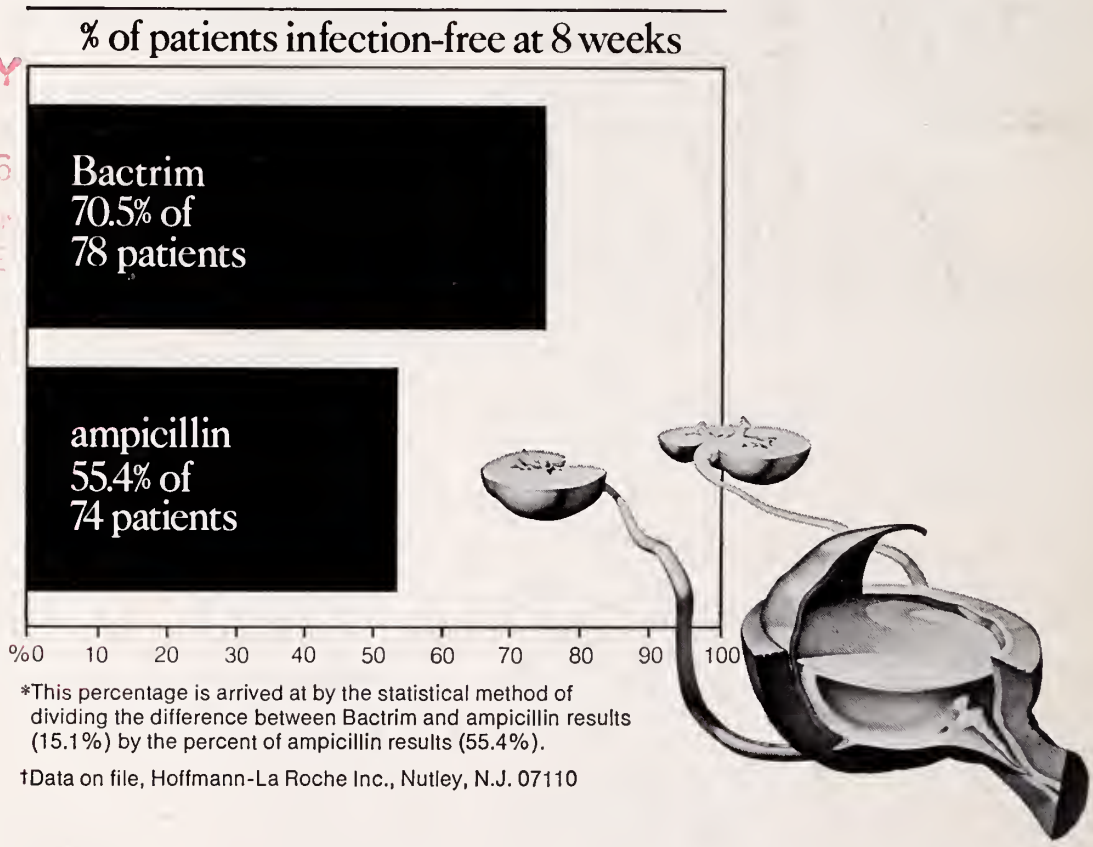
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

In a multicenter study of patients with chronic or frequently recurrent urinary tract i

2EAST 103RD ST
NEW YORK N.Y.
10029

Bactrim™ was 27.2%* more effective than ampicillin keeping patients infection-free for 8 weeks†

LIBRARY
FEB 1 1 1976
NEW YORK ACADEMY OF MEDICINE



*This percentage is arrived at by the statistical method of dividing the difference between Bactrim and ampicillin results (15.1%) by the percent of ampicillin results (55.4%).

†Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110

Bactrim™ DS
(160 mg trimethoprim and 800 mg sulfamethoxazole)
double strength tablets
Just 1 tablet B.I.D.

Bactrim™
(80 mg trimethoprim and 400 mg sulfamethoxazole)
2 tablets B.I.D.

Please see summary of product information on preceding page.

ROCHE

BALCONY

AMERICAN REVOLUTION BICENTENNIAL 1776-1976

JOURNAL OF THE Mississippi STATE MEDICAL ASSOCIATION

MARCH 1976

BECOTIN®
Vitamin B Complex

BECOTIN® with VITAMIN C
Vitamin B Complex with Vitamin C

BECOTIN®-T
Vitamin B Complex with Vitamin C, Therapeutic

MI-CEBRIN®
Vitamins-Minerals

MI-CEBRIN T®
Vitamin-Minerals Therapeutic

AND A WIDE VARIETY OF OTHER PHARMACEUTICALS

DISTA

DISTA PRODUCTS COMPANY
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

400944

This Month . . . Myocardial Scanning, Gallstone Ileus, Postoperative Reflux Gastritis

M.S.M.A.

Both often



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) Ⓒ IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

HOW MUCH DO YOU MAKE?

That's how much you could lose . . . and more . . . if an accident or illness totally disabled you and you were unable to continue your practice. Not only would you lose your personal income, but the cost of maintaining your office would also continue. YOU COULD LOSE TWICE AS MUCH as another person might because you have two sets of expenses. To help you fight this possibility, the Mississippi State Medical Association makes available to members two excellent programs that help cover both ends of your expense picture: the INCOME PROTECTION PROGRAM for personal expenses, and the tax-deductible PROFESSIONAL OVERHEAD EXPENSE PROTECTION PROGRAM for your business expenses.

■ TO HELP PAY YOUR PERSONAL EXPENSES, THERE'S MSMA'S INCOME PROTECTION PROGRAM

When you're not practicing, your income stops. Just paying your everyday expenses could run into a great deal of money, draining your savings, especially if your income were cut off indefinitely. The MSMA INCOME PROTECTION PROGRAM can pay as much as $2,000 a month income replacement benefits payable for up to LIFETIME for accident-caused disabilities, TO AGE 65 for disabilities resulting from illness. And, you choose when you want the benefits to begin — either the 31st or the 91st day of disability — to give you the coverage that best fits your own individual needs.

■ TO HELP PAY BUSINESS COSTS, PROFESSIONAL OVERHEAD EXPENSE PROTECTION'S FOR YOU

Whether you're there or not, it costs the same amount of money each month to keep your office open. But, with no money coming in, it could really put you in a serious financial position. You need the businessman's insurance with your practice in mind — the MSMA PROFESSIONAL OVERHEAD EXPENSE PROTECTION PROGRAM. It works for you when you can't. It'll pay 100% of your covered fixed overhead costs — even up to $3,500 a month, the maximum amount available. And, the benefits are available for as long as 18 months. Premiums may be deducted as a direct business expense, too.

WANT TO KNOW MORE? WRITE TODAY!

Protect yourself and your family. Protect your investment in your business. Find out more about these exceptional MSMA Programs. Write to THOMAS YATES & CO., P. O. Box 1054, Bankers Trust Plaza Building, Jackson, Mississippi 39205 for brochures describing the benefits, features, limitations, exclusions and premiums of each Plan.

These Plans Are Offered By

THOMAS YATES & CO.
P.O. Box 1054
Bankers Trust Plaza Building
Jackson, Mississippi 39205

THOMAS YATES & CO. has been awarded the seal of the American Institute of Professional Association Group Insurance Administrators — "In recognition of professional excellence in serving clients with an integrity worthy of the highest trust." Membership in the Institute is by invitation only.

THESE PLANS ARE MSMA SPONSORED

The INCOME PROTECTION PROGRAM and the PROFESSIONAL OVERHEAD EXPENSE PROTECTION PROGRAM are officially sponsored and endorsed by the Mississippi State Medical Association exclusively for its members.

Also sponsored by the MSMA are the HOSPITAL MONEY PLAN, MAJOR MEDICAL PLAN, EXCESS MAJOR MEDICAL PLAN, and TERM LIFE INSURANCE. Brochures for these programs are also available.

Underwritten By

CONTINENTAL CASUALTY Co.
Association Group Division
CNA Plaza • Chicago, Illinois 60685

Volume XVII
Number 3
March 1976

JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

• EDITOR
W. MONCURE DABNEY, M.D.
• ASSOCIATE EDITORS
GEORGE H. MARTIN, M.D.
MYRON W. LOCKEY, M.D.
• MANAGING EDITOR
NOLA GIBSON
• PUBLICATIONS COMMITTEE
LAWRENCE W. LONG, M.D.
Chairman
FRANK L. BUTLER, JR., M.D.
T. A. BAINES, M.D.
and the editors
• THE ASSOCIATION
JACK A. ATKINSON, M.D.
President
LYNE S. GAMBLE, M.D.
President-Elect
JAMES P. SPELL, M.D.
Secretary-Treasurer
C. D. TAYLOR, JR., M.D.
Speaker
R. FASER TRIPLETT, M.D.
Vice Speaker
CHARLES L. MATHEWS
Executive Secretary
H. CODY HARRELL
Assistant Executive Secretary
WILLIAM F. ROBERTS
Legal Counsel

THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION is owned and published monthly by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, $15.00 per annum; $2 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

CONTENTS

ORIGINAL PAPERS

Myocardial Scanning in Coronary Artery Disease **61** ANGEL K. MARKOV, M.D., ROBERT O. SMITH, PATRICK H. LEHAN, M.D., JERRY C. GRIFFIN, M.D., GASTON RODRIQUEZ, M.D., and HARPER K. HELLEMS, M.D., Jackson, MS

Problems in Abdominal Surgery: II. Postoperative Reflux Gastritis **67** WILLIAM O. BARNETT, M.D., Jackson, MS

SPECIAL ARTICLE

Radiologic Seminar CLX: Gallstone Ileus: A Case Report **70** JEFFREY L. SAULS, M.D., Jackson, and C. FOSTER LOWE, M.D., McComb, MS

EDITORIALS

The Disabled Physicians Act **75** W. MONCURE DABNEY, M.D., Crystal Springs, MS

Readership Survey Results Are Released **75** NOLA GIBSON, Jackson, MS

THIS MONTH

The President Speaking **74** "Simple Solutions Don't Solve Complex Problems"

Medical Organization **81** MSMA Annual Session Returns to Jackson; Headquarters Is New Holiday Inn Downtown

Copyright 1976, Mississippi State Medical Association



Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

Automatic Major Medical.

On January 1, 1976, Blue Cross & Blue Shield of Mississippi, Inc. implemented a new procedure for processing and paying Major Medical benefits. It's called "Automatic Major Medical," and it's designed to save time and paperwork for provider and subscriber alike.

Now, the Plan can process both Basic and Major Medical benefits from a Basic claim. The need for filing two separate claims covering the same services will no longer be necessary in many cases. Major Medical benefits can be automatically paid direct to the provider of services based on the Basic claim when the claim contains the subscriber's signature authorizing such payment.

For providers, this means an improved cash flow and simplified claims handling. For subscribers, it means less filing and more expedient payment.

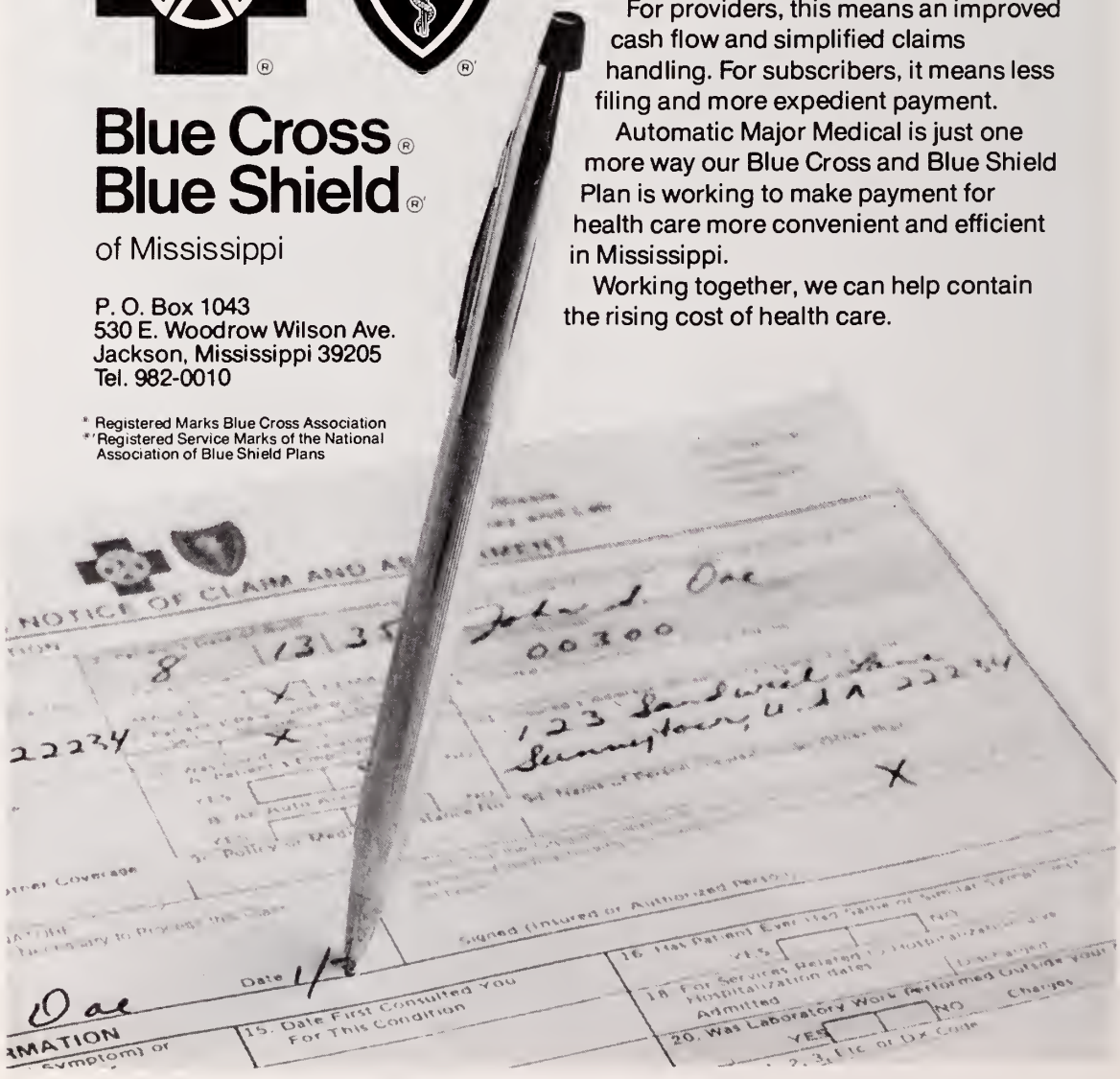
Automatic Major Medical is just one more way our Blue Cross and Blue Shield Plan is working to make payment for health care more convenient and efficient in Mississippi.

Working together, we can help contain the rising cost of health care.

Blue Cross® Blue Shield®
of Mississippi

P. O. Box 1043
530 E. Woodrow Wilson Ave.
Jackson, Mississippi 39205
Tel. 982-0010

® Registered Marks Blue Cross Association
® Registered Service Marks of the National Association of Blue Shield Plans



NEWSLETTER

March 1976

Dear Doctor:

An Ad Hoc Committee on Medical Discipline, approved by the House of Delegates at the 1975 Clinical Convention, has been established by the AMA Board of Trustees. The committee will study disciplinary mechanisms of medical associations and determine the effectiveness of medical discipline; recommend appropriate modifications in medical self-regulation, appropriate legislation and governmental regulations; recommend improvements in state legislation and licensure board regulations.

> The committee will also review the procedures by which hospitals limit privileges within the individual physician's competence and study the relationship between medical discipline and malpractice claims. The House called for preliminary report at 1976 annual convention and urged societies to cooperate.

HEW Secretary David Mathews has told a House of Representatives subcommittee that Professional Standards Review Organizations (PSRO) will be operational or in some stage of planning in all 203 PSRO areas during fiscal year 1977. The president's budget proposal calls for $89 million funding for PSRO next year, nearly double the present funding.

Jay Constantine, the chief health staffer of the powerful U.S. Senate Finance Committee, in a speech before the American Hospital Association called President Ford's Catastrophic plan for Medicare beneficiaries the "Medicare cutback bill" and assured the AHA that no Democratic congress would pass Ford's health block grant proposal.

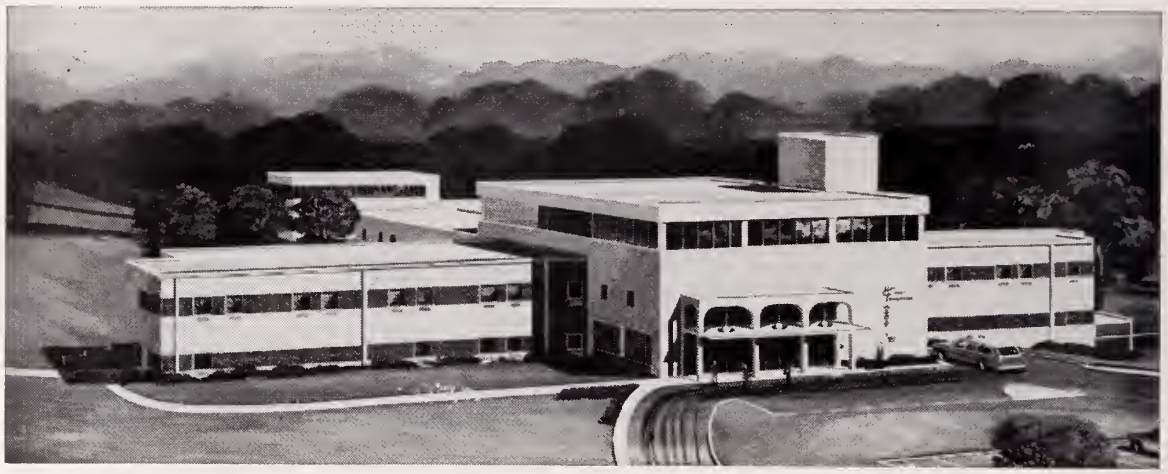
Private health insurers covered nearly 9 out of every 10 citizens under age 65 in 1974, according to the Health Insurance Association of America. Some 96 percent of those covered, for some or all of their hospital expenses, also had surgical-expense protection and 89 percent had nonsurgical, medical-expense insurance. Health insurance benefits paid in 1974 reached a new high of $28.1 billion.

Miscellaneous: The Bureau of Health Manpower has awarded 7 contracts to medical schools for training some 500 refugee physicians from Indochina to qualify as licensed medical doctors, including the University of Arkansas. President Ford's Medicare cost-containment proposals covering physician's fees and hospital reimbursement have drawn heavy opposition from both the AMA and the AFL-CIO.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor



HILL CREST HOSPITAL

For Intensive Treatment of Psychiatric Disorders

This 101-bed non-governmental psychiatric hospital provides modern facilities for diagnosis and treatment of patients with all degrees of illness, including those who show severely disturbed behavior. Alcoholic and drug abuse patients are also accepted.

In addition to care by psychiatrists and by consultants in all medical specialties, the treatment program includes occupational, recreational, and physical therapy, social services, and tutoring. Emphasis is on short-term, intensive treatment of voluntary patients.

Hill Crest is a member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Alabama Hospital Association, Birmingham Regional Hospital Council.

Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved. Blue Cross Participating Hospital.

ADMINISTRATOR: Robert V. Sanders

HILL CREST HOSPITAL

HILL CREST FOUNDATION, INC.

6869 Fifth Avenue South **Birmingham, Alabama 35212**

PHONE: 205-836-7201

Gastrointestinal Radiology Meet Set

The department of Diagnostic Radiology of the University of Kentucky Medical Center will present a Symposium on Gastrointestinal Radiology at the Lexington Hilton Inn April 28-30. The program is designed for the practicing radiologist, gastroenterologist and gastrointestinal surgeon.

The format consists of brief lectures, panel discussions, case presentations, ultrasound and computerized tomography techniques. Prior to the meeting the registrants will receive by mail sets of x-rays of the cases to be discussed.

The guest faculty consists of Drs. Robert Berk, Joseph Bookstein, George Leopold, Roscoe Miller, Thomas F. Meany, Jerome F. Wiot, and Bernard Wolf.

The fee for the symposium is $300. For more information and registration forms write Dr. Frank Lemon, Office of Continuing Education, College of Medicine, University of Kentucky, Lexington, KY 40506.

Endocrinology Studied At Nashville

The American College of Physicians will sponsor a three-day postgraduate course entitled "Endocrinology: Clinical and Scientific Aspects" on April 21-23, 1976, in Nashville, TN. The course will be held in conjunction with the Vanderbilt University School of Medicine.

The course is planned to provide the clinician with a thorough updating in the field of clinical endocrinology, including the topics of diabetes, thyroid abnormalities, gastrointestinal hormones, and special problems in pediatric endocrinology.

The American College of Physicians postgraduate courses have been approved by the American Medical Association Advisory Committee on Continuing Medical Education, and may be used to fulfill Catagory 1 requirements for the AMA Physician's Recognition Award.

Directors of the Nashville postgraduate course are Drs. Grant W. Liddle and Paul E. Slaton, Jr.

helping you change things for the better

Canton Exchange Bank

A FULL SERVICE BANK

"Your Account Handled in Strict Confidence"

Each depositor insured to $40,000

Branch Offices

Canton East Branch
Bank Of Madison
Bank Of Ridgeland

FDIC

"Our 95th Year Of Continuous Service"

Federal Deposit Insurance Corporation

No. 3
As potent as the pain it relieves.

e.g. the pain of
surgical convalescence



NOT TOO LITTLE
- as potent as the pain you need to relieve in patients with fractures, sprains, strains, wounds, contusions, and the pain of surgical convalescence
- unlike acetaminophen/codeine combinations, it does not sacrifice anti-inflammatory action

NOT TOO MUCH
- potent—yet not excessive
- addiction liability low

NOT TOO EXPENSIVE
- brand-name quality, yet reasonable in cost
- readily available in both hospital and local pharmacies

CIII CONVENIENCE
- telephone Rx in most states, up to 5 refills in 6 months at your discretion (where state law permits)

EMPIRIN® COMPOUND WITH CODEINE NO. 3

codeine phosphate* (32.4 mg) gr ½
Each tablet also contains: aspirin gr 3½, phenacetin gr 2½, caffeine gr ½. *Warning—may be habit-forming.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

DATELINE

There Are Now More Women Surgeons

Chicago, IL - More women medical students are entering the male-dominated surgical specialties and opting for general or plastic surgery rather than the traditional women's field of obstetrics and gynecology, according to a recent article in the American College of Surgeons Bulletin. The article states that the number of women surgeons increased 17.9 percent between 1970 and 1974. Of 93,000 surgeons in practice in 1974, 2,510 were women.

The Self-Employed Pay More SSA

Washington, D.C. - Self-employed physicians will pay $94.89 more to the Society Security program next year. The maximum tax level for the self-employed will be $1,208.70, the government said. For salaried individuals the maximum tax will rise to $895.05 from $824.85 this year. Tax rates of 5.85 percent for each employer and employee and 7.9 percent for the self-employed will not change, but the taxable base is increased to $15,300.

Met Life Phone Speeds Policies

New York, NY - Metropolitan Life Insurance Company's solution to delay in policy issue due to physician delay is the Medical Recording Service, a telephone recording system that simplifies the physician's job and speeds policy issue. All the physician needs to do is dial the company collect and dictate his or her report. Then, to avoid any misinterpretation, Metropolitan provides the doctor with a transcript of the recording.

New Ultrasound Being Developed

Menlo Park, CA - Some forms of atherosclerosis can now be diagnosed without risk or discomfort to the patient, using a new ultrasonic instrument currently being developed at Stanford Research Institute. The first model is undergoing tests at the Mayo Clinic. The instrument produces television images of a small cross-section of tissue including arteries and surrounding muscles, veins and organs. The only contact with the patient is a small water-filled bag resting lightly against the skin.

Family Planning Film Is Available

Jackson, MS - "Family Planning: It Makes Good Sense," a slide presentation produced by the Mississippi State Board of Health, is now available. The 15-minute film examines the health department's family planning program and provides information to those who desire family planning services. There are currently 60,000 women in the state under program supervision. The presentation stresses that one should have children by choice, not chance.



"I do not believe you can do today's job with yesterday's methods and be in business tomorrow." Nelson Jackson

Dr. Nathaniel Chapman, as brilliant as he was in his day, could not survive in today's complex business world. His methods and business procedures belong in the 19th century. TODAY'S PROBLEMS SHOULD BE SOLVED BY TODAY'S METHODS.

Unlike Dr. Chapman, you have Systemedics to help you solve today's complex medical practice problems. We'll be happy to show you how our system creates in-office efficiency and collects more money for you. It will please you while eliminating clerical drudgery in your office.

Your staff need only send in a daily voucher on each patient served. We'll handle the rest.

Act now—why wait. Install today's methods and realize the many benefits now being enjoyed by the thousands of doctors on the Systemedics system.

Let us show you how this will more than pay for itself through increased collections—collection of receivables that you couldn't previously identify or collect.

Systemedics/AMS

P O BOX 191, LAUREL, MISSISSIPPI 39440
PHONE (601) 425-2815

Send information about your services.

Name .....

Address .....

City ..... State .....

Telephone .....

Neuro-ENT Course Planned

The University of Pittsburgh School of Medicine announces the Third Course in Clinical Neuro-Otolaryngology, Mar. 25-27, 1976, at the Eye and Ear Hospital of Pittsburgh.

This course is designed for the practitioner of otorhinolaryngology or neurology and residents in training, to aid in the understanding of the various neurological aspects of otorhinolaryngological disorders. The focus will be on practical clinical evaluation and management.

Topics covered will include the function, clinical evaluation, and disorders of the vestibular system, audition, taste, olfaction, speech, swallowing, and the facial nerve. There will be brief formal presentations. However, the emphasis will be on panel conference-type discussions, with case presentations, to encourage the active discussion and participation of the faculty and the participants.

The course is acceptable for AMA credit hours in Category 1 and is sponsored by the Department of Otolaryngology and the Division of Continuing Education, University of Pittsburgh, School of Medicine.

For further information, write to: Dr. Sidney N. Busis, Course Director, Eye and Ear Hospital of Pittsburgh, Pittsburgh, PA 15213.

Scientific Advances Studied At Lexington Course

The American College of Physicians will sponsor a three-day postgraduate course entitled "Frontiers of Medical Science: The Clinician as Translator" on April 12-14, 1976, in Lexington, KY. The course will be held in conjunction with the University of Kentucky College of Medicine.

The course is planned to relate recent scientific advances in physiology, biochemistry, and pathology to practical applications in clinical rheumatology, hematology and immunology, gastroenterology and endocrinology. Lectures and workshops will describe how these concepts can benefit patients in present practice.

The American College of Physicians' postgraduate courses are approved for American Medical Association Category 1 credit.

The course is being planned under the co-direction of Drs. Frank R. Lemon and J. W. Hollingsworth.

Influenza A/Victoria Is in Mississippi

Influenza A/Victoria is a variant of influenza A/Port Chalmers (last year's strain) and influenza A/Hong Kong. The strain was first isolated in Victoria, Australia in the fall of 1975 and it has been active in the Pacific since October. Influenza A/Victoria was first isolated in the USA (Hawaii) in December 1975. In January and early February, it has been isolated from patients in at least 11 states scattered across the continent, reports the State Board of Health.

The virus had been isolated in two Mississippi patients as of Feb. 6. Influenza like illness has been occurring in the past weeks and has been heavy in some areas. Schools in Marshall and Clark counties were temporarily closed because of high absenteeism among teachers and pupils. SBH estimates of influenza activity in Mississippi are based on surveys conducted by local health departments in which a small number of local physicians are telephoned and queried about the prevalence of influenza like illness among their patients.

Influenza is characterized by the sudden onset of fever, chills, headache, myalgia, sore throat and cough. Gastrointestinal symptoms may occur but are uncommon. Recovery is the rule and occurs in 2-7 days. Elderly persons, persons with chronic pulmonary disease or other debilitating illnesses may experience severe illness and death. Treatment for the acute illness is symptomatic. Antibiotics are not indicated unless bacterial superinfection has occurred. Gamma globulin is not preventive or therapeutic.

Early reports suggest that influenza A/Victoria differs enough from A/Port Chalmers that the available vaccines do not convey much protection. School closings do not limit the spread of disease but may be unavoidable because of excessive absenteeism.

The future course of influenza A/Victoria in Mississippi is unpredictable. Spread into currently uninvolved areas of the state is to be expected and foci of intense activity may occur.

Watch for the Complete Annual Session Program in The April Issue Of the Journal MSMA.

Is there a tablet containing *only* an expectorant and *only* Glyceryl Guaiacolate? YES!

1. Patient acceptable tablet dose.
2. Single entity expectorant.
3. Measured tablet dose.
4. Sugar-free tablet.

An identifiable white, scored tablet which significantly stimulates the secretion of respiratory tract fluid.

HYTUSS TABS

(GLYCERYL GUAIACOLATE 100mg.)





Composition: Each sugar-free compressed tablet contains glyceryl guaiacolate 100mg. **Action and Use:** This preparation utilizes the effective expectorant action of glyceryl guaiacolate which significantly stimulates the secretion of respiratory tract fluid. The increased flow of less viscid fluid favors expectoration and has a demulcent effect on the tracheobronchial mucosa. The primary usefulness of Hytuss Tabs is to promote the change from a dry, unproductive cough to a productive cough. Hytuss is therefore useful in treating coughs due to the common cold, bronchitis, laryngitis, tracheitis, pharyngitis, influenza and the measles. The expectorant action of Hytuss may also provide symptomatic relief in some chronic respiratory disorders when the patient experiences spasms of dry nonproductive coughing. **Precautions:** Extremely large amounts may cause nausea and vomiting. **Administration and Dosage:** *Adults*—1 tablet four times daily. *Children*—6 to 12 years of age; ½ tablet 3 or 4 times daily. HOW SUPPLIED: White, scored, sugar-free, tablet in bottles of 100 - 1,000 - 5,000. **Product Identification Mark:** Hy. **Literature Available:** On request.

Available through all drug wholesalers.

Hyrex

HYREX COMPANY
832 South Cooper
Memphis, Tenn. 38104



What should a girl, unwed and in need of help do, when she finds herself pregnant?

If you will refer her to us—the Volunteers of America—we will make certain that she is well cared for and her baby is given the opportunity for a healthy, happy life. Our services include full pre-natal, delivery and post-natal care in modern, attractive surroundings—counseling by trained and compassionate professionals and placement of the infant through adoption, if desired.

For a confidential discussion, phone Mrs. O'Brien of the Volunteers of America in New Orleans (504) 891-7713.

South Will Be Site for NHI Hearings

Knoxville and New Orleans will be among five sites for public hearings on national health insurance to be conducted by Rep. Dan Rostenkowski's Health Subcommittee of the U. S. House of Representatives Committee on Ways and Means.

Tentatively scheduled for Mar. 25-26, and May 20-21, respectively, the hearings are viewed by many as an attempt by Rep. Rostenkowski and organized labor to stir up support for enactment of national health insurance by Congress this year. Rostenkowski is said to favor labor's Health Security proposal, the most notable sponsor of which is Senator Edward Kennedy.

Rostenkowski's committee has been involved in a dispute with Rep. Paul G. Rogers' Health and Environment Committee of the Committee on Interstate and Foreign Commerce regarding who has jurisdiction over NHI. Rogers' committee has recently ended several weeks of hearings on NHI.

MSMA has requested time before Rostenkowski's committee when it appears in New Orleans. In addition to Knoxville and New Orleans the committee will also appear at Chicago, San Francisco and Salem, Oregon.

Gynecologic Endocrinology Course Scheduled

The Department of Obstetrics and Gynecology at The University of Tennessee Center for the Health Sciences, Memphis, will sponsor a three-day postgraduate course for clinicians on gynecologic endocrinology at the Hilton Inn-Memphis Airport, Mar. 11-13, 1976.

The diagnosis and management of the major gynecologic endocrine disorders will be discussed by 11 visiting faculty and 10 local faculty. Guest faculty include: Drs. Carl E. Cassidy, Charles Flowers, Joseph W. Goldzieher, Robert B. Greenblatt, Jerome M. Hershman, Ronald K. Kalkhoff, Janet W. McArthur, Robert L. Rosenfield, Pentti K. Siiteri, Leon Speroff and Michael E. Yannone.

An interesting and informative program is also planned for the wives, including a pilgrimage to restored antebellum homes.

For further information and registration contact: Dr. James R. Givens, 800 Madison Avenue, Memphis, TN 38163.

Heart Disease Symposium Set for Jackson

A two-day symposium on heart disease will be held Mar. 19-20 at St. Dominic-Jackson Memorial Hospital in Jackson. The symposium is being sponsored by the Mississippi Heart Institute and the Mississippi Heart Association.

Guest faculty will include: Dr. Mark Silverman, professor of medicine, Piedmont Hospital, Emory University, Atlanta; Dr. Robert Frye, director, Cardiovascular Laboratory, Mayo Clinic, Rochester; Dr. Norman M. Kaplan, Deputy Vice-President for Research Program, American Heart Association, Dallas; and Dr. John H. Collins, chief, Cardiovascular Surgery, Peter Bent Brigham Hospital, Harvard Medical School, Burton, MA.

This CME activity is accredited for 10 credit hours in category I for the physician's recognition award of the American Medical Association; credit 10 hours, MSMA category I; credit has been approved for 10 elective hours by the American Academy of Family Practice.

For further information write Mississippi Heart Institute, St. Dominic-Jackson Memorial Hospital, 969 Lakeland Drive, Jackson, MS 39216.

Decentralized Education Conference Scheduled

A program on Decentralized Education in Family Medicine will be held Mar. 31-April 1 at the Royal Sonesta Hotel in New Orleans.

The conference is jointly sponsored by the family medicine departments of The University of Mississippi School of Medicine, Louisiana State University School of Medicine and The University of Alabama College of Community Health Sciences.

This conference is designed to acquaint teachers of family medicine with the problems, the opportunities and the mechanisms for developing extramural training programs.

Included on the program are Drs. W. R. Gillis, University of Mississippi; Edmund D. Pellegrino, Yale University; Hilliard Jason, Association of American Medical Colleges; William R. Willard, The University of Alabama; Hiram B. Curry, University of South Carolina School of Medicine; and Fitzhugh Mayo, Medical College of Virginia. There will also be a discussion by a panel of financial advisers from the universities of Alabama, Louisiana and South Carolina.

it's the real thing



70-37

Mississippi Council of Coca-Cola Bottlers

WAYNE MEDICAL LABORATORY, INC.

Providing complete and/or reference laboratory service to hospitals, clinics and physicians.

General and specialized tests are offered. Profiles, Thyroid Studies, Pap Smears, Electrophoresis and other Laboratory procedures.

SINCE 1965

Send for fee schedule:

Wayne Medical Lab., Inc.
212 West Seventh St.
Laurel, MS 39440

601-426-2221 TWX—510-960-1993

consider the effect on coexisting diabetes when you prescribe a vasodilator*



(POSTERIOR VIEW OF PANCREAS)

no interference in the management of the diabetic patient has been reported with

VASODILAN®
(ISOXSUPRINE HCl)

TABLETS, 20 mg.

the compatible vasodilator

Mead Johnson LABORATORIES

© 1976 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL-54117

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
March 1976, Vol. XVII, No. 3

ORIGINAL PAPERS

Myocardial Scanning in Coronary Artery Disease

ANGEL K. MARKOV, M.D., ROBERT O. SMITH, PATRICK H. LEHAN, M.D., JERRY C. GRIFFIN, M.D., GASTON RODRIQUEZ, M.D., and HARPER K. HELLEMS, M.D.
Jackson, Mississippi

SURGICAL TREATMENT of coronary artery atherosclerosis currently offers a possibility to alter the natural course of the disease. Therefore, with the current emphasis on an aggressive approach to early recognition of coronary heart disease, a single non-invasive technique for assessing regional myocardial perfusion would be of great clinical value. Although coronary angiography remains the most reliable tool for the detection of coronary artery lesions, new methods for estimating relative coronary blood flow changes,[1] and for topographically delineating underperfused,[1-4] ischemic,[1-5] infarcted[6, 7] and/or scarred myocardium have promised certain advantages. Among these techniques the most promising are those which offer the simplicity and safety of a non-invasive approach. The technique to be described using potassium-42 (^{42}K), a non-invasive isotope scanning procedure, was originally developed at the University Medical Center in Jackson by Love and associates.[2] This technique involves myocardial imaging using a high energy collimator after the injection of ^{43}K at rest and during treadmill exercise.[5] We would like to review the current status and application of this method now involving the use of potassium-43 (^{43}K), a more favorable isotope for human studies.

Methods and Material. A group of 24 patients, suspected of having coronary artery disease, underwent myocardial scanning with ^{43}K. An isotope dose of 1 millicurie was administered in a peripheral vein. Immediately afterward 4 serial resting antero-posterior and 4 left anterior oblique 5.5 minute serial scans were obtained.

In a group of 24 patients with coronary artery disease, regional myocardial perfusion was assessed by myocardial scanning after intravenous injection of potassium-43 while at rest and also during treadmill exercise. When rapid serial scanning was begun simultaneously with administration of the radionuclide, the first scan at rest was usually as indicative of abnormal perfusion as those made under conditions of myocardial stress by exercise.

In an attempt to detect stenotic lesions of the coronary artery which still allow adequate resting flow, each patient underwent a maximum graded treadmill exercise test under electrocardiographic monitoring. Isotope was then administered at the point of angina pectoris, fatigue, or when target heart rate had been reached without symptoms. After the recovery period, i.e. when the heart rate had returned to that recorded before exercise, the patient was transported to the scanning laboratory where myocardial imaging was accomplished in the same manner as described for the resting scans. Forty-eight studies were performed on 24 patients, one scan on each patient at rest and one after treadmill exercise testing.

From the Department of Medicine, University of Mississippi Medical Center and Veterans Administration Hospital, Jackson, MS.

Due to the fact that the physical half life of ^{43}K is 22.4 hours, it was necessary to separate the studies by at least three days in order to eliminate any residual activity. For potassium-43, the maximum dose per study was 20 microcuries per kilogram of body weight. The total whole-body absorbed radiation dose has been computed to be 600-700 millirads/millicurie depending on the method of calculation.[8, 9] The ^{43}K was diluted in 10 ml. of saline and injected as a bolus in one of the peripheral veins.

A digital rectilinear dual detector isotope scanner was designed and constructed for the detection of high energy gamma radiation. Raw data from the scanner was stored on perforated tape for processing and future reference. Mathematical analysis was performed on a Hewlett-Packard Model 2115A digital computer. A computer controlled display system provided good permanent two dimensional displays on Polaroid film. The schematics are of A-P and left anterior oblique views.

Coronary angiography was performed on all patients. The angiographic data were interpreted by two cardiologists who had not seen the corresponding myocardial scans, while the myocardial perfusion images were interpreted by two observers who were unaware of the patients' clinical presentations or coronary arteriographic findings.

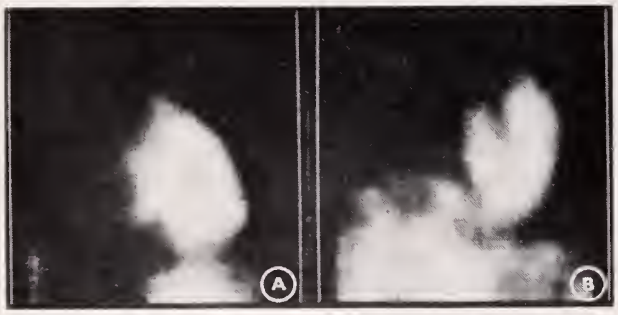


Figure 1. All scans were composed of 32 x 32 elements in a 6 x 6 inch array. A small digital computer was used for 9-point averaging which smoothed count rate fluctuations. The Polaroid photographs were made from an intensity modulated cathode-ray-tube display of a 64 x 64 array which was a computer expansion of the original averaged array. Approximately one mCi of potassium-43 was given as an intravenous bolus and scanning started without delay. A: Scan from anterior aspect of patient BS without clinical or angiographic evidence of abnormal coronary arteries. B: Left anterior oblique (LAO) view from the same patient. The myocardium usually appears as a "doughnut" but the basal portion may have been outside the range of the collimator because the myocardium in this instance was elongated.



Figure 2. A: Anterior view from patient JDB with more than 95 per cent stenosis of anterior descending branch (LAD) of left coronary artery. The white arrow points out an area of low counts corresponding to an apical aneurysm which resulted from the stenosed LAD. B: LAO view. The black arrow is along the left ventricular (LV) wall and the ^{43}K counts were much lower in this area than in the LV wall supplied by the circumflex branch (CFX).

RESULTS

The myocardial images in all subjects with normal coronary and left ventricular angiograms showed homogenous distribution of the isotope. Although there were variations of total isotope accumulation in the myocardium among the normal patients, no abnormal perfusion patterns were noted. In a scan of a normal heart most of the isotope activity represents the left ventricle. The left ventricle has an ovoid shape and is best seen on the A-P view. The left anterior oblique view was also recorded but is more difficult to interpret because of overlapping of the right coronary artery with the left anterior descending. However, it does provide some additional information about the patency of circumflex and left anterior descending branches of the left coronary artery (see Figure 1).

In the patients having transmural infarction, the myocardial scans revealed regions of decreased isotope activity corresponding to the areas of vascular occlusion or abnormal myocardial contraction noted on angiography. These abnormalities were demonstrated in the same location on both the resting and exercise scans in each patient. In the case illustrated in Figure 2, the patient had an anterior myocardial infarction by EKG. On myocardial scan there was decreased activity in the area supplied by the left anterior descending coronary artery. Later coronary angiography demonstrated 95 per cent occlusion of the left anterior descending coronary artery near its origin from the left main coronary artery (see Figure 2). The left anterior oblique view shows practically no isotope uptake in this region.

Dyskinesis or ventricular aneurysm, a common finding on angiography in patients with coronary artery disease, can also be detected by myocardial scanning. This condition is usually manifest as irregularities in the outline of the area corresponding to the left ventricle as illustrated in Figure 3. The corresponding left ventriculogram made at 30° right anterior oblique position confirmed the presence of an aneurysm in the suspected location.



Figure 3. A: Anterior view from patient JST who had 50-70 per cent stenosis of the right coronary artery (RCA), 95 per cent stenosis of the LAD, 50 per cent occlusion of the CFX and an apical aneurysm. The arrow points to the apex which had very low counts and was not visible after ~ 40 per cent background subtraction. In this view, the apex is usually supplied by the LAD. Therefore, severe stenosis of the LAD is suggested by this scan. B: LAO view from the same patient in which the arrow points out a hole in the "doughnut" ring. As this region is normally supplied by the posterior descending branch of the right coronary artery, stenosis along its course was suggested. Because the LV wall margins along the CFX were slightly irregular, a less significant lesion was suspected.

A comparison between the results of the myocardial scans and the corresponding angiographic studies is shown in Table I. In only three cases were the scans interpreted to be positive for coronary artery disease, while angiography was negative. In two of these cases abnormal ^{43}K uptake by the myocardium was attributed to cardiomyopathy. The interpretation of these myocardial scans was labeled as "diffuse small coronary artery disease," and one could notice on Figure 4 the "patchy" appearance of the heart image.

The enhancement of abnormal perfusion patterns by exercise was not found to be significant as claimed by Zaret and Strauss.[5] In our study there was little difference between the post-exercise and resting scans in patients with angina pectoris (see Figure 5). There are at least two possible explanations for this discrepancy. The resolution of the scanner and the method of analysis may offer more



Figure 4. A: Anterior view of patient PR whose angiographic report indicated no stenotic lesions in either coronary artery. From scanning, minimal obstructions were thought to be in the RCA, LAD and perhaps even in the CFX. Based on the hemodynamic data, cardiomyopathy was the final diagnosis. B: LAO view which shows the normal "doughnut" shape.

sensitivity in our method. In addition, we have noted that the time period from injection of the isotope until the scan is taken is critical due to sequential changes in the level of isotope in the various regions of the myocardium. Our technique enables us to complete a scan as early as 5 min. post-injection, while in Zaret's technique the initial resting scan is completed only after 15 min. It is in this initial scan that we usually see the most pronounced irregularity of isotope distribution.



Figure 5. A: Anterior view of patient JDB whose scans at rest are shown in Figure 2. A comparison of the two figures shows very similar formations. In this instance, the patient was exercised to tolerance which produced ST segment depression and then the ^{43}K was rapidly administered and scanning started. The arrow points to the apical region with low counts. B: LAO view of exercise scan. The arrow is along the septal wall of the LV which is usually supplied by branches of the LAD.

DISCUSSION AND CONCLUSIONS

Many new non-invasive radioisotopic methods for estimation of various parameters of cardiac function have been developed in the past few years. In our opinion, the ^{43}K scanning technique is potentially

TABLE I

Patient	Age	Procedure	RCA	LAD	CFX	L. Ventriculogram	Remarks
1 ..... LHJ	56	Rest	++	+	+		Scan is suggestive of apical aneurysm
		Exer.	++	+	+		
		Angio.	100%	100%	10-20%	Apical aneurysm	
2 ..... GCB	45	Rest	±	+	+	–	Probable multiple small lesions
		Exer.	±	+	+	–	
		Angio.	30%	10%	98%		Same as above
3 ..... JST	52	Rest	+	++	+		Scan is suggestive of apical aneurysm
		Exer.	+	++	+		
		Angio.	50-70%	95%	50%	Apical aneurysm	
4 ..... HDP	55	Rest	+	+	+		
		Exer.	+	+	+		
		Angio.	60-70%	20-30%	50-70%		
5 ..... RBS	51	Rest	+	+	+		Scan is suggestive of apical aneurysm RCA best artery
		Exer.	+	+	+		RCA best artery
		Angio.	prox. 25% dist. 75%	100%	50-75%	Apical akinesis	Antero-apical mural clot
6 ..... NJB	47	Rest	++	+	+		Probable multiple lesions
		Exer.	++	+	+		Probable multiple lesions
		Angio.	95%	100%	30%		
7 ..... JDB	48	Rest	+	++	+		Scan is suggestive of apical aneurysm CFX best
		Exer.	+	++	+		CFX best
		Angio.	20%	95%	10-20%	Apical aneurysm	
8 ..... PEF	45	Rest	+	+	+	–	
		Exer.	+	+	+	–	
		Angio.	20%	30-70%	10-20%		
9 ..... GB	52	Rest	+	+	+		CFX best artery
		Exer.	+	+	+	–	CFX best artery
		Angio.	50-75%	100%	30-50%	+Apical akinesis	
10 ..... PR	41	Rest	+	+	±	–	
		Exer.	+	+	±	–	
		Angio.	–	–	–		Cardiomyopathy
11 ..... HM	45	Rest	+	+	+	–	
		Exer.	+	±	±	–	
		Angio.	100%	25%	30%		
12 ..... RWS	56	Rest	+	+	+		Scan is suggestive of apical aneurysm
		Exer.	+	+	+		
		Angio.	75%	30%	30%	Apical aneurysm	Left main 50% stenosis

13	CB	43	Rest	±	+	++		
			Exer.					Would not return for exercise
			Angio.	75%	30%	75%	Inf. wall akinesis	
14	JRH	53	Rest	prox. +	+	+		
			Exer.	+	++	++		
			Angio.	50-70%	95%	50%	Hypokinetic anterior wall	
15	DLH	51	Rest	+	++	++		More demonstrative than exercise
			Exer.	+	++	+		Enlarged heart
			Angio.	10%	99%	95%	Akinesis of apex & ant. wall	Enlarged heart
16	TH	50	Rest	++	+	+		Enlarged heart
			Exer.	++	+	+		Enlarged heart
			Angio.	100%	75%	10-20%	Post-inf. wall akinesis	
17	WCW	47	Rest	+	+	+	-	
			Exer.	±	+	+	-	
			Angio.	100%	20%	10-20%		
18	JH	58	Rest	++	++	+	-	Scan shows large inf. apical aneurysm
			Exer.	++	++	+	-	
			Angio.	100%	100%	80%	Large inf. apical aneurysm akinesis	Extensive collaterals from RCA to LAD
19	RP	63	Rest	+	+	+		
			Exer.	+	+	+		
			Angio.	70-80%	80-90%	80-90%		
20	JB		Rest	+	+	+		Scan is suggestive of apical aneurysm
								Possible collaterals from RCA
			Exer.	+	+	++		Possible collaterals from RCA
			Angio.	30%	100%	95%	Apical aneurysm	Collaterals from RCA to LAD
21	WD	44	Rest	+	+	+	-	
			Exer.	+	+	+	-	
			Angio.	50%	50%	50%		
22	EJ	43	Rest	+	+	++		
			Exer.	+	+	++		RCA best artery
			Angio.	30%	75-85%	100%		
23	BW	42	Rest	+	+	+	-	Large LV, Pt. had coronary bypass surgery
			Exer.					
			Angio.	80-95%	80%	100%		Dilated LV
24	NE	58	Rest	+	+	+	-	Uptake patchy. Multiple lesions, large LV
			Exer.	+	+	+		
			Angio.	95%	100%	95%		Multiple lesions, dilated LV

Rest = The isotope was administered at resting conditions; Exer. = The patient underwent maximum graded treadmill exercise test and ^{43}K was given at the point of angina pectoris, fatigue or when target heart rate was reached; Angio. = % stenosis in the lumen of the vessel as demonstrated by selective coronary angiography; RCA = right coronary artery; LAD = anterior descending branch of the left coronary artery; CFX = circumflex branch of the left coronary artery.

one of the most important and most useful. We feel the demonstration of infarcted or scarred heart muscle with ^{43}K can be reliably accomplished. Its use in the detection of less advanced coronary artery disease is more controversial. It has been claimed[5] that arteriosclerotic lesions of the coronary artery which allow normal resting flow (less than 75 per cent obstruction of the vessel's lumen) are impossible to detect by scanning the patient at rest. Zaret et al[5] have suggested that by post-exercise scanning one can detect such lesions. This method seems logical; yet, in our laboraory we have found that the information obtained from the resting scan is sufficient to detect even these less advanced stenotic lesions. In fact, the abnormalities noted on the resting scan were practically the same as those in the post-exercise scans.

In explaining this discrepancy between our data and that of Zaret[5] we have recently employed coronary vasodilators in order to detect stenotic lesions which are not severe enough to limit coronary blood flow in the normal resting state. Studies in animals using coronary vasodilator drugs having no significant vasodilator effect on the peripheral circulation suggest that coronary blood flow can be greatly increased in this manner without the necessity for significant elevations of cardiac output. An obvious advantage of this method as opposed to exercise is that for various reasons not all coronary artery disease patients are able to undergo enough exercise to raise coronary blood flow sufficiently. In such patients, by using a coronary vasodilator drug, the functional reserve capacity of the coronary circulation could still be assessed. These canine studies[10] suggest that such drugs may play a role in improving the sensitivity of non-invasive myocardial imaging techniques for detecting early coronary artery disease in man. ★★★

2500 N. State Street (39216)

ACKNOWLEDGEMENT

The ^{43}K was supplied by the Isotope Development Laboratory, Oak Ridge National Laboratories, and by Dr. J. Kenneth Poggenburg, Jr.

This work was supported by Grants HL 07628 and HL 05651 from the National Heart and Lung Institute, National Institutes of Health, and by the Mississippi Heart Association's Love Chair of Cardiovascular Research, which is held by Dr. Patrick H. Lehan.

REFERENCES

1. Cannon, P. J., Dell, R. B. and Dwyer, E. M., Jr.: Measurement of Regional Myocardial Perfusion in Man with ^{133}Xenon and a Scintillation Camera. J. Clin. Invest. 51:964, 1972.
2. Love, W. D., Smith, R. O. and Pulley, P. E.: Mapping Myocardial Mass and Regional Coronary Blood Flow by External Monitoring of ^{42}K or ^{86}Rb Clearance. J. Nucl. Med. 10:702, 1969.
3. Carr, E. A., Gleason, G., Shaw, J. and Krontz, B.: The Direct Diagnosis of Myocardial Infarction by Photoscanning After Administration of Cesium-131. Am. Heart J. 68:627, 1964.
4. Collier, R. E., Matson, J. I., Tomme, J. W. and Hyland, J. W.: Correlation of Myocardial Photoscanning and Coronary Arteriography in Angina Pectoris. Radiology 91:310, 1968.
5. Zaret, B. L., Martin, N. D., McGowan, R. L., Strauss, W., Wells, H. P. and Flamm, M. D., Jr.: Rest and Exercise Potassium-43 Myocardial Perfusion Imaging for the Noninvasive Evaluation of Aortocoronary Bypass Surgery. Circulation 49:688-695, 1974.
6. Holman, L. B., Dewanjee, M. K., Idoine, J., Fliegel, C. P., Davis, M. A., Treves, S. and Eldh, P.: Detection and Localization of Experimental Myocardial Infarction with ^{99m}Tc—Tetracycline. J. Nucl. Med. 14: 595, 1973.
7. Parkey, R. W., Bonte, F. J., Meyer, S. L., Atkins, J. M., Curry, G. C., Stokely, E. M. and Willerson, J. T.: A New Method for Radionuclide Imaging of Acute Myocardial Infarction in Humans. Circulation 50:540, 1974.
8. Hurley, P. J., Cooper, M., Reba, R. C. et al: ^{43}KCl: A New Radiopharmaceutical for Imaging the Heart. J. Nucl. Med. 12:516-519, 1971.
9. Skrabal, F., Glass, H. I., Clark, J. C. et al: A Simplified Method for Simultaneous Electrolyte Studies in Man Utilizing Potassium-43. Int. J. Appl. Radiat. Isot. 20:677-681, 1969.
10. Markov, A. K., Smith, R. O., Lehan, P. H., Flowers, Wm. M., Jr., Hellems, H. K. and Keister, T. L.: Vasodilator Induced Myocardial Perfusion Patterns. Sou. Med. J. In press. (Presented to the 15th Annual Meeting of the Southeastern Chapter of the Society of Nuclear Medicine, St. Petersburg, October 31, 1974).

Premature deaths for cigarette-caused diseases total 300,000 yearly. The Mississippi Lung Association advises "No Smoking . . . for life and breath." No Smoking signs and information are available, free of charge, from the Mississippi Lung Association, P. O. Box 9865, Jackson, MS 39206.

Problems in Abdominal Surgery
II. Postoperative Reflux Gastritis

WILLIAM O. BARNETT, M.D.
Jackson, Mississippi

HITHERTO IT HAS not been easy to explain recurrent epigastric pain following operations for duodenal ulcer where normal or low levels of gastric acid were present. There is little doubt now that some individuals are unable to tolerate continuing exposure of the remaining gastric mucosa to normal duodenal content representing a combination of bile, pancreatic juice and succus entericus. The syndrome has been referred to variously in the literature as reflux gastritis, alkaline gastritis, bilious vomiting and regurgitation gastritis.[1, 2, 3]

Pathology. The great majority of postoperative patients do quite well with continued bathing of the gastric mucosa by duodenal content as regularly occurs following a Billroth II gastrojejunostomy. The few who have trouble evidence histologic changes in the gastric mucosa which are readily demonstrated by endoscopic biopsy. These include elongation of gastric glands, inflammatory changes, denudation of epithelium and intestinalization of the gastric mucosa with the appearance of Paneth cells. Of interest is the fact that these histologic changes usually revert to normal after diversion of duodenal content from the stomach.

Diagnosis. Reflux gastritis has been observed after all gastric operative procedures which destroy the pyloric valve mechanism. It would appear that it more commonly follows gastrojejunostomy after gastric resection, but the condition has been diagnosed after Billroth I gastrectomy as well as drainage procedures combined with vagotomy. These patients complain of epigastric pain which is described as being different from the discomfort experienced preoperatively. Before the operation, the pain usually appeared when the stomach was empty, being relieved following the ingestion of food. The postoperative pain is not experienced while the stomach is empty. The taking of food is usually productive of epigastric pain and relief is obtained instantaneously after regurgitation. The vomitus is usually observed to contain large quantities of bile. This pain has been observed to appear anywhere from 1 to 15 years after gastric surgery. Weight loss is prominent among these patients. The expected nutritional disadvantages of partial gastric removal are operational, but an additional responsible factor relates to a decrease in calorie intake. This occurs, of course, because of apprehension associated with expected discomfort which regularly attends eating. Gastric analysis usually reveals hypo or achlorhydria. Gastroscopic examination represents a necessary adjuvant in the diagnostic evaluation of these patients. They commonly evidence considerable quantities of bile colored gastric fluid which has refluxed into the stomach. The mucosa is found to very friable and fiery red. These changes characteristically begin near the stoma and extend to involve the mucosa for a considerable distance. Biopsy of the gastric mucosa can be expected to reveal histologic changes as described above.

This paper is the second in a series on problems in abdominal surgery to be published every other month by the JOURNAL MSMA. *Postoperative reflux gastritis is discussed with the author describing pathology; diagnosis; differential diagnosis including marginal ulcer, dumping syndrome, afferent loop syndrome, efferent loop obstruction, and small gastric pouch; the treatment; and an illustrative case.*

DIFFERENTIAL DIAGNOSIS

There are, of course, several conditions other than reflux gastritis which may cause concern following gastric surgery. Careful exclusion of these syndromes is mandatory if the desired improvement is to be achieved following therapy.

From the Department of Surgery, University of Mississippi Medical Center, Jackson, MS.

Marginal Ulcer. In most cases with intestinal ulceration near its anastomosis with the stomach, the symptoms will be very similar to those experienced before the original surgical procedure. Burning, aching, gnawing are some of the descriptive terms used by these patients. X-ray examination usually does not demonstrate these lesions with regularity in contrast to duodenal ulceration in the surgically unaltered gastrointestinal tract. The most effective diagnostic tool here is gastroscopy by means of which the ulcerating lesion can usually be visualized.

Dumping Syndrome. This troublesome problem is characterized by epigastric discomfort, hyperperistalsis, bloating, fullness and abdominal cramps. True pain seldom occurs. Common vasomotor symptoms attending dumping include weakness, dizziness, pallor, vertigo, a desire to lie down, sweating, palpitation and tachycardia. Assumption of a horizontal position usually results in relief of symptoms. The uncommon syndrome of late dumping manifests symptoms which attend hypoglycemia.

Afferent Loop Syndrome. The acute type of this syndrome is characterized by abdominal pain, fever, tachycardia, abdominal tenderness, nausea and vomiting, shock, and elevated amylase. There is no bile in the vomitus. Chronic afferent loop syndrome is difficult to differentiate from alkaline gastritis. In fact, I am persuaded that many cases formerly diagnosed as chronic afferent loop syndrome were actually alkaline gastritis.

Efferent Loop Obstruction. Findings here are specifically those of gastric outlet obstruction. Constant nausea and vomiting are present and upper gastrointestinal x-ray studies reveal obstruction.

Small Gastric Pouch. This problem is not encountered with the frequency which was formally observed before more conservative practices in the removal of gastric tissue were employed by surgeons. Anemia, weight loss and epigastric fullness result from the inadequate gastric reservoirs. True pain, which is the usual finding with alkaline gastritis, is not usually observed in these patients.

TREATMENT

Some patients with mild symptoms of alkaline gastritis may be improved by nonsurgical measures. The administration of cholestyramine has been observed to be beneficial in some cases.[3] A bland diet appears to be helpful, but antacid therapy cannot be expected to provide significant benefit. Most patients with advanced alkaline gastritis necessitate surgical intervention. The objective of surgical procedures is to divert duodenal content away from the gastric mucosa. This may be attempted in several different ways as depicted in Figure 1. The Henle loop interposition was among the earlier operations applied to this problem. Results have not, in general, been as satisfactory as with some of the later methods. The Tanner 19 and the Roux-en-Y are similar in the application of the principle of division of alkaline juices at a point some distance below the stomach on the efferent loop. Our experience has involved the Roux-en-Y procedure.

SURGICAL PROCEDURES WHICH HAVE BEEN USED FOR REFLUX GASTRITIS

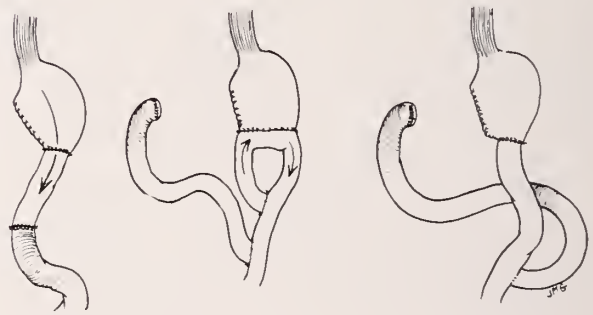


Figure 1. Three of the more frequently employed operative procedures for alkaline gastritis.

This type of alkaline diversion has been applied in six cases with gratifying improvement in all instances.

ILLUSTRATIVE CASE

D.J., a 52-year-old male, was admitted to the University Medical Center complaining of continual nausea and vomiting, epigastric pain and weight loss. Two years previously he sustained a vagotomy and antrectomy with a gastroduodenostomy for intractable ulcer symptoms. For one year after the operation he had been symptom free and was regularly working at his job as a telephone repairman. One year prior to admission, he began to experience epigastric pain with occasional nausea and vomiting. These symptoms became more progressive with severe weight loss because of inability to retain ingested food. Of interest was the fact that while continuous nasogastric suction was in effect, his abdominal discomfort was completely relieved. Appraisal of gastric acid production revealed achlor-

hydria. On gastroscopic examination the gastric mucosa was inflammed and friable. Biopsy revealed findings consistent with reflux gastritis. Because of strong evidence suggestive of reflux gastritis, operative intervention was advised and accepted by the patient. The duodenum was first dissected free, transected at the gastroduodenal anastomosis and the duodenal stump was closed. The jejunum was next divided below the ligament of Treitz following which the distal end was anastomosed to the stomach. The proximal end of the jejunum was then anastomosed to the side of the jejunum (see Figure 2). Eight days after this operation he necessitated an additional laparectomy for the resection of gangrenous bowel which resulted from adhesions in the pelvic, related to a previous operation. It is now one and a half years after the surgery for reflux gastritis and the patient is doing quite well. He has gained 15 pounds, has no epigastric discomfort and is regularly working at his job as a lineman for the phone company.

SUMMARY

A significant minority of patients suffers from complications related to exposure of the gastric mucosa to alkaline duodenal contents after surgery for gastric and duodenal lesions. These patients are characterized by nausea and vomiting, epigastric pain, weight loss, and hypo or achlorhydria. Gastroscopic examination reveals gross and microscopic changes consistent with reflux gastritis. A large majority of these patients respond favorably to remedial surgical procedures which effectively shunt duodenal content away from the stomach. ★★★

2500 North State Street (39216)

DISMANTLING OF GASTRODUODENOSTOMY AND CONSTRUCTION OF ROUX-EN-Y GASTROJEJUNOSTOMY

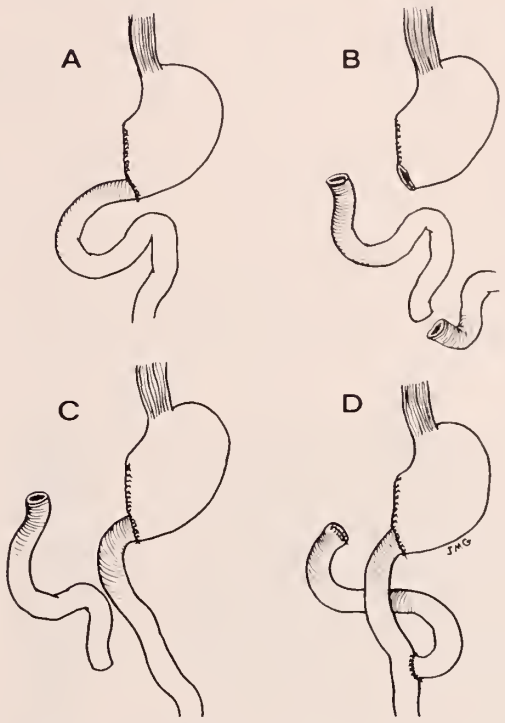


Figure 2. Remedial operation employed in the reported case.

REFERENCES

1. Barlett, M. D. and Burrington, J. D.: Bilious Vomiting After Gastric Surgery. Arch. Surg. 79:34, 1968.
2. Herrington, J. L., Sawyers, J. L. and Whitehead, W. A.: Surgical Management of Reflux Gastritis. 180:526, 1974.
3. VanHeerden, J. A., Phillips, S. F., Adson, M. A. and McLlrath, D. C.: Postoperative Reflux Gastritis. Am. J. Surg. 129:82, 1975.

BICENTENNIAL QUOTE OF THE QUARTER

I am well aware of the toil and blood and treasure, it will cost us to maintain this Declaration. Yet through all the gloom I see the rays of ravishing light and glory. This is our day of deliverance. With solemn acts of devotion we ought to commemorate it. With pomp and show, games, sports, guns, bonfires, and illuminations from one end of the continent to the other, from this time forth forevermore.

John Adams
July 3, 1776
(Reprinted from *Mississippi Bicentennial Newsletter*)

Radiologic Seminar CLX: Gallstone Ileus: A Case Report

JEFFREY L. SAULS, M.D.,* Jackson, and
C. FOSTER LOWE, M.D.,† McComb, Mississippi

GALLSTONE ILEUS is an important, but relatively uncommon, cause of small bowel obstruction. It may present with a classic triad of roentgenographic signs that may be observed on a plain abdominal film. These consist of air in the biliary tree, large ectopically located gallstones, and dilated small bowel loops with air-fluid levels. When these typical findings are present, the diagnosis of gallstone ileus is rapid and reliable. It is not unusual, however, for a case of gallstone ileus to present with only one or two of the typical findings. Rarely, a case may present with a nonspecific pattern on plain abdominal films. The use of barium or other contrast material then becomes very important in diagnosis.

CASE REPORT

M.C., an 84-year-old black female, was admitted to Southwest Mississippi Regional Medical Center with abdominal pain, anorexia, and vomiting. She gave a history of chronic right upper quadrant pain and fatty food intolerance. On physical examination she appeared dehydrated, but in no acute distress. She had mild abdominal distension.

Abdominal x-rays including recumbent and erect projections were obtained. Close observation reveals air in the biliary tree. There is no apparent small bowel dilatation (see Figure 1). An upper G.I. series was performed, and this revealed a dilated stomach with delayed gastric emptying. The duodenal bulb eventually filled, and there was noted to be a diverticulum-like structure adjacent to the duodenal bulb. Subsequently there was filling of the cystic duct and the proximal biliary radicals (see Figure 2). After several hours the common duct filled, and there was noted to be moderate dilatation of the small bowel down to the distal jejunum (see Figure 3). A preoperative diagnosis of gallstone ileus was made, and the patient was taken promptly to surgery. A large calculus measuring 3 cm. in diameter was found wedged in the distal jejunum, and it was removed through an enterotomy without



Figure 1. An erect film of the abdomen reveals air in the biliary system. A few air-fluid levels are seen in some short segments of small bowel, but there is no significant dilatation of the small bowel.

Sponsored by Mississippi Radiological Society.
* From the Department of Radiology, University of Mississippi Medical Center, Jackson, MS.
† Southwest Mississippi Regional Medical Center, McComb, MS.



Figure 2. A film obtained approximately 30 minutes after ingestion of barium reveals a fistula between the duodenal bulb and gallbladder. The cystic duct and the hepatic ducts are also filled. Note that the duodenal bulb and loop show no deformity or spasticity.

difficulty. There was extensive inflammatory tissue around the gallbladder and duodenum, and further surgical intervention was not felt to be indicated. The patient made an uneventful recovery and was discharged in satisfactory condition.

DISCUSSION

This case emphasizes the importance of contrast material in the diagnosis of an "atypical" presentation of gallstone ileus. Approximately one-third of the cases of gallstone ileus will present with plain film findings which will allow a definitive diagnosis of gallstone ileus. The appearance on plain films depends largely on the site of impaction and the duration of the obturation. The stone usually lodges in the terminal ileum and this often results in dilatation of the entire small intestine. Gas in the biliary system is one of the most constant findings in gallstone ileus. The gas enters the biliary tree from the intestine through the fistula produced by the large gallstone. The fistula usually develops between the gallbladder and duodenum, but it may erode into another viscus such as the stomach, small bowel, or colon.

The use of contrast examinations may increase the accuracy in diagnosis to as high as 90 per cent. The upper G.I. series is the study of choice. It may reveal a localized collection of barium adjacent to the duodenum. This can be differentiated from a penetrating ulcer, for there should be no spasticity or deformity of the duodenum. The diagnosis is readily made if the biliary system fills as in this case. Delayed films showing the small bowel are important for they may demonstrate dilatation of the small bowel and possibly an intraluminal filling defect at the site of obstruction as was noted in this case report.



Figure 3. This film obtained several hours after administration of oral barium reveals the cholecystoduodenal fistula with opacification of the common bile duct. The small bowel is diffusely dilated down to a rounded intraluminal filling defect (arrow). This proved to be the site of the impacted gallstone in the distal jejunum.

A barium enema may be performed as another approach. The barium may be refluxed into the terminal ileum, and the stone may be demonstrated as a round, intraluminal filling defect. Oral and intravenous cholangiographic studies show non-opacification of the gallbladder, and they are of little help in definitive diagnosis.

Prompt diagnosis and treatment is important, for a delay may lead to serious complications such as perforation, necrosis, or abscess formation. Gallstone ileus develops most commonly in elderly females, so this group of patients should receive particular attention when small bowel obstruction is suspected. Even when the plain film is nonspecific, the use of contrast examinations may allow an early diagnosis and thus avoid serious complications. ★★★

2500 North State Street (39216)

REFERENCES

1. Balthazar, E. J. and Schechter, L. S.: Gallstone Ileus: The Importance of Contrast Examinations in the Roentgenographic diagnosis. Am. J. Roent. Rad. Ther. & Nucl. Med. 125:374-379, 1976.
2. Eisenman, I. J., Finck, E. J. and O'Laughlin, B. J.: Gallstone Ileus: Review of Roentgenographic Findings and Report of New Roentgen Sign. Am. J. Roent., Rad. Ther. & Nucl. Med. 101:361-366, 1976.
3. Kirkland, K. C. and Croce, E. J.: Gallstone Intestinal Obstruction: Review of Literature and Presentation of 12 Cases, Including 3 Recurrences. J.A.M.A. 176:494-497, 1961.
4. Shehadi, W. H.: Roentgenologic Observations in Cases of Fistulae of Biliary Tract. J.A.M.A. 174:2204-2208, 1960.

Every time you take a breath, your lungs are exposed to airborne hazards. The Mississippi Lung Association, 353 N. Mart Plaza, Jackson, MS 39206, has information on the health hazards of air pollution.

12-hour claims
are nothing new.

12-hour relief is.



NEW

Novafed® A Capsules

Each capsule contains pseudo-ephedrine hydrochloride 120 mg. and chlorpheniramine maleate 8 mg.

Controlled-Release Decongestant Plus Antihistamine

It goes the distance.





Clinical studies confirm full 12-hour effectiveness.

For years, patients have heard of drugs providing long-lasting relief. But after six or eight hours, they often run out of relief. And it's too soon to take the next dose.

Now, with Novafed A, Dow introduces a prescription capsule with 12-hour effectiveness in relieving allergy and hay fever symptoms. Placebo-controlled clinical studies show that the high level of decongestant in Novafed A provides relief for as long as 12 hours. At the same time, its antihistamine relieves the patient's itchy eyes and runny nose *without* the excessive dryness of anticholinergic agents.

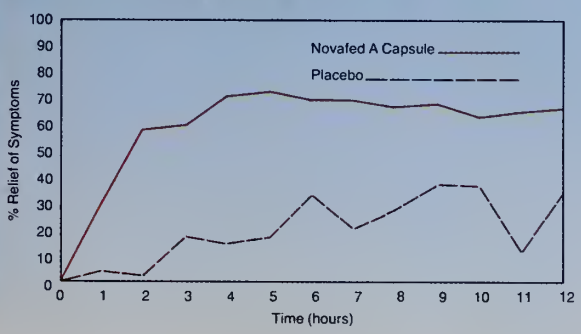
Prompt onset of effect is followed by full 12-hour relief.

(Please refer to the following page for bioavailability studies and prescribing information.)



Patients with severe pollen allergies were tested during hay fever season in a countryside environment and asked to rate severity of five different symptoms on a scale of 1 to 4.

Clinical Study: Degree of Relief from Itchy Eyes and Nose and Throat, Watery Eyes, Runny Nose*



*Unpublished data, Medical Department Files, Dow Pharmaceuticals, The Dow Chemical Company, Indianapolis, Indiana.

DOW®

Specialists in Cough and Cold Care





NEW

Novafed® A Capsules

Each capsule contains pseudoephedrine hydrochloride 120 mg. and chlorpheniramine maleate 8 mg.

Controlled-Release Decongestant Plus Antihistamine

It goes the distance.



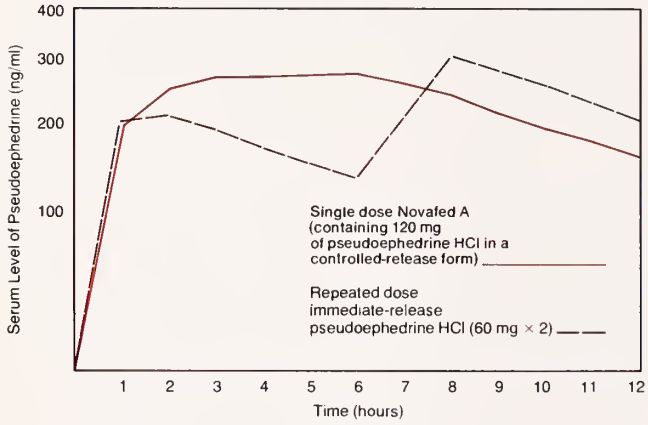
Prompt onset and sustained serum levels over 12 hours.

A bioavailability study confirmed that the sustained 12-hour action of Novafed A was comparable to that of immediate-release medication taken at 6-hour intervals.

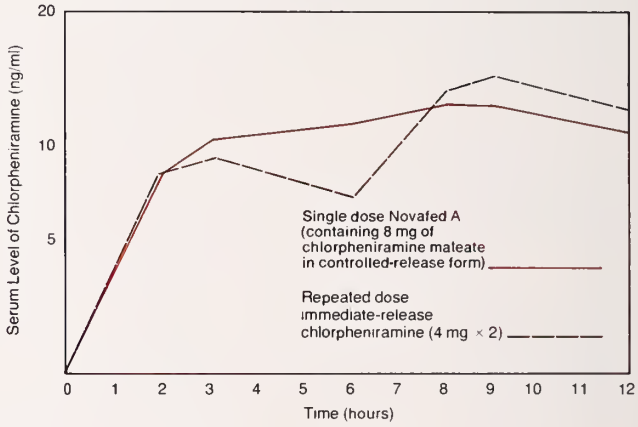
The chart at the left shows the serum levels of pseudoephedrine. Initial serum levels following one Novafed A Capsule were comparable to those following a single dose of 60 mg. pseudoephedrine hydrochloride in an immediate-release form. Serum levels of pseudoephedrine over a 12-hour period following a single dose of Novafed A were also comparable to those obtained by an immediate-release form taken every 6 hours.

The chart at the right shows the serum levels of chlorpheniramine. Initial serum levels following one Novafed A Capsule were comparable to those following a single dose of 4 mg. chlorpheniramine maleate in an immediate-release form. Serum levels of chlorpheniramine over a 12-hour period following a single dose of Novafed A were also comparable to those obtained by an immediate-release form taken every 6 hours.

Comparison of Mean Serum Levels of Pseudoephedrine Following Novafed A and an Immediate-Release Reference Formulation*



Comparison of Mean Serum Levels of Chlorpheniramine Following Novafed A and an Immediate-Release Reference Formulation*



*Unpublished data, Medical Department Files, Dow Pharmaceuticals, The Dow Chemical Company, Indianapolis, Indiana.

DESCRIPTION: Each NOVAFED A capsule contains 120 mg. of pseudoephedrine hydrochloride and 8 mg. of chlorpheniramine maleate. The specially formulated pellets in each capsule are designed to provide continuous therapeutic effect for about 12 hours. Nearly one-half of the active ingredients is released soon after administration and the remainder is released slowly over the remaining time period.

ACTIONS: NOVAFED A combines the action of a nasal decongestant, pseudoephedrine hydrochloride, and an antihistamine, chlorpheniramine maleate. These ingredients are combined to provide prompt and sustained nasal and upper respiratory decongestant and antihistaminic action.

INDICATIONS: NOVAFED A is indicated for the relief of nasal congestion and eustachian tube congestion associated with the common cold, sinusitis and acute upper respiratory infections. It is also indicated for perennial and seasonal allergic rhinitis, vasomotor rhinitis, allergic conjunctivitis due to inhalant allergens and foods and for mild, uncomplicated allergic skin manifestations of urticaria and angioedema. Decongestants in combination with antihistamines have been used for many years to relieve eustachian tube congestion associated with acute eustachian salpingitis, aerotitis media, acute otitis media and serous otitis media. NOVAFED A may be given concurrently, when indicated, with analgesics and antibiotics.

CONTRAINDICATIONS: Symphathomimetic amines are contraindicated in patients with severe hypertension, severe coronary artery disease, and in patients on MAO inhibitor therapy. Antihistamines are contraindicated in patients with narrow-angle glaucoma, urinary retention, peptic ulcer, during an asthmatic attack, and in patients receiving MAO inhibitors.

Children under 12: NOVAFED A controlled-release capsules should not be used in children less than 12 years of age.

Nursing Mothers: Pseudoephedrine is contraindicated in nursing mothers because of the higher than usual risk for infants from sympathomimetic amines.

Hypersensitivity: This drug is contraindicated in patients with hypersensitivity or idiosyncrasy to sympathomimetic amines or antihistamines. Patient idiosyncrasy to adrenergic agents may be manifested by insomnia, dizziness, weakness, tremor or arrhythmias.

WARNINGS: Sympathomimetic amines should be used judiciously and sparingly in patients with hypertension, diabetes mellitus, ischemic heart disease, increased intraocular pressure, hyperthyroidism, or prostatic hypertrophy. Sympathomimetics may produce central nervous system stimulation and convulsions or cardiovascular collapse with accompanying hypotension.

Antihistamines may impair mental and physical abilities required for the performance of potentially hazardous tasks, such as driving a vehicle or operating machinery, and mental alertness in children. Chlorpheniramine maleate has an atropine-like action and should be used with caution in patients with increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension or in patients with a history of bronchial asthma.

Do not exceed recommended dosage.

Use in Pregnancy: The safety of pseudoephedrine for use during pregnancy has not been established.

Use in Elderly: The elderly (60 years and older) are more likely to have adverse reaction to sympathomimetics. Overdosage of sympathomimetics in this age group may cause hallucinations, convulsions, CNS depression, and death. Therefore, safe use of a short-acting sympathomimetic should be demonstrated in the individual elderly patient before considering the use of a sustained-action formulation.

PRECAUTIONS: This drug should be used with caution in patients with diabetes, hypertension, cardiovascular disease and hyperreactivity to ephedrine. The antihistaminic may cause drowsiness and ambulatory patients who operate machinery or motor vehicles should be cautioned accordingly.

ADVERSE REACTIONS: Hyperreactive individuals may display ephedrine-like reactions such as tachycardia, palpitations, headache, dizziness, or nausea. Patients sensitive to antihistamines may experience mild sedation.

Sympathomimetic drugs have been associated with certain untoward reactions including fear, anxiety, tenseness, restlessness, tremor, weakness, pallor, respiratory difficulty, dysuria, insomnia, hallucinations, convulsions, CNS depression, arrhythmias, and cardiovascular collapse with hypotension.

Possible side effects of antihistamines are drowsiness, restlessness, dizziness, weakness, dry mouth, anorexia, nausea, headache and nervousness, blurring of vision, heartburn, dysuria and very rarely, dermatitis.

DRUG INTERACTIONS: MAO inhibitors and beta adrenergic blockers increase the effect of sympathomimetics. Sympathomimetics may reduce the antihypertensive effects of methyldopa, mecamylamine, reserpine and veratrum alkaloids. Concomitant use of antihistamines with alcohol, tricyclic antidepressants, barbiturates and other central nervous system depressants may have an additive effect.

DOSAGE AND ADMINISTRATION: One capsule every 12 hours. Do not give to children under 12 years of age.

CAUTION: Federal law prohibits dispensing without prescription.

HOW SUPPLIED: NOVAFED A is supplied in red and orange colored hard gelatin capsules, monogrammed with the Dow diamond followed by the number 109, in bottles of 100.

DOW

DOW PHARMACEUTICALS
The Dow Chemical Company
Indianapolis, IN 46268

Specialists in cough and cold care

BUT MY FEW DOLLARS

WON'T MAKE ANY

DIFFERENCE



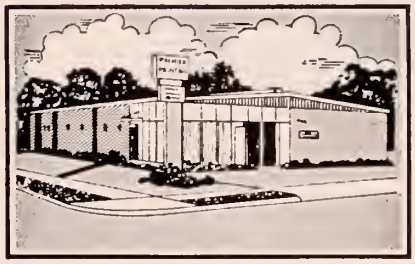
Thankfully not everybody says that. We know different. Your dues, added to mine, and to everybody else's dues, can make a difference. But, maybe you would rather go to work for the government?

If not join us in 1976 . . . and bring along a friend.

JOIN MPAC TODAY

PRINTING — OFFICE SUPPLIES

EQUIPMENT — FURNITURE



Premier Printing Company

2485 West Capitol Jackson, Mississippi

Phone 352-4091

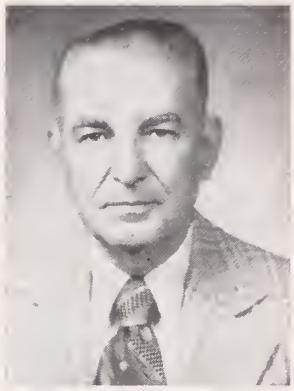
Have You Made Your Reservations?

MISSISSIPPI STATE MEDICAL ASSOCIATION

108th ANNUAL SESSION

May 3-6, 1976
Holiday Inn Downtown
Jackson, Miss.

Excellent Scientific Program
Scientific and Technical Exhibits
Fellowship and Fun



The President Speaking

"Simple Solutions Don't Solve Complex Problems"

JACK A. ATKINSON, M.D.
Brookhaven, Mississippi

IN HIS BOOK "Escape from Freedom," Dr. Erich Fromm warns of the ever present temptation to seek simple solutions to complex problems. It seems to me that a classic example of this denial of complexity is seen in the Federal Trade Commission's charge of "restraint of trade" against the American Medical Association because of this organization's ethical code against advertising by its members. The Federal Trade Commission charged that, because physicians do not advertise, competition is being reduced, prices are being fixed, and consumers are being denied the information they need to obtain medical care at a reasonable cost.

The basic assumption of this claim is that the practice of medicine is fundamentally the same as the sale of groceries. Now this attitude is not surprising for today we are being bombarded with a language that suggests a way of life. Intrusion of the lingo of business and commerce has introduced the concept of the "Health Industry." Patients are called "consumers," physicians have become "providers," and "health care is now being" delivered.

Dr. Charles Aring, in speaking to this subject, has reminded us that regardless of how this lingo is being perpetrated, it cannot be allowed to become orienting, for medicine is not a utility or a business. This is not professional arrogance, this is just the way it is.

In medicine the stakes are considerably higher than in the purchase of merchandise. One wants the best available and every one should get just that. There is just no such thing as bargain basement medicine.

The rising cost of health care is a complex problem involving many factors. The ravages of inflation, the advancement of medical technology, and the increase in malpractice insurance premiums are but a few of these factors. Such a simple solution as price comparison will not solve the problem. ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XVII, NUMBER 3
MARCH 1976

EDITORIALS

The Disabled Physicians Act

House Bill #487, enacted during the 1975 meeting of the state legislature, gives the State Board of Health much more latitude in dealing with "sick doctors." Let no one be concerned that the rights of an individual may be forfeited by this act or that the Board may arbitrarily deny privileges without due process.

It is an act to provide for the restriction, suspension or revocation of the license of any physician to practice medicine because of his inability to practice medicine with reasonable skill and safety to patients due to physical or mental illness, including deterioration through the aging process or loss of motor skill or abuse of drugs, including alcohol.

We now have an act in which the State Board of Health can limit, to varying extents, the physician scope of practice, to monitor his rehabilitation and to require expert evidence of his ability to function. In the past it has largely been a matter of "all or none," that is either to continue full privileges or to revoke his or her license.

The law protects the board and those persons providing information to the board and those designated as an examining committee by the board where acting in good faith, without malice from liability and action for damages.

It should be the duty of every practicing physician in our state to report gross incompetence in his peers as defined above. It is only through such action that we can help to alleviate or prevent further increase in malpractice claims and costs of insurance and combat the accusation that we "don't clean our own house." In conclusion it is my opinion that the action of the board of health has never been punitive, particularly since I have been a member and that its only concern is first to protect the public and secondly to assist in any way possible for the rehabilitation of the physician in question.

W. Moncure Dabney, M.D.
Editor
Crystal Springs, MS

Readership Survey Results Are Released

The Journal MSMA conducted a readership survey last fall to determine whether the publication is meeting the needs of the membership.

A computer-selected random sample of 272 member physicians was sent the questionnaire and a followup mailing was made three weeks later. One hundred forty-eight questionnaires were returned for a return rate of 54.5.

Fifty-one per cent of the respondents felt a monthly publication is an essential function for a medical society, while 33.8 per cent marked "good if you can afford it" and 7 per cent said "unnecessary."

Fifty-five per cent said they read the Journal MSMA every month; 18 per cent said 5 or 6 times a year; 19 per cent replied sometimes and 1.3 per cent said they never read the journal.

When they do read the journal, 12.8 per cent read all the way through it; 47.9 per cent leaf through it; 18 per cent read half of it; 11.5 per cent read only the scientific content; and 2 per cent read only the news and features.

When asked to check the categories they'd like to see more of, 40 per cent said scientific articles; 18 per cent socioeconomic articles; 34.4 per cent state, regional and national medical news; and 34 per cent MSMA policy and activities.

Physicians surveyed were also asked to rank

journal departments in the order of interest. Results indicated no great variance except for medical news and book reviews which received high ratings.

The second page of the questionnaire was a listing of medical specialties for the respondent to mark which category he or she would like to see more of in the journal. Physicians tended to indicate articles in their own specialty; however, family practice was most often chosen and cardiovascular disease, gynecology, pediatrics and general surgery also received high ratings.

From the results of the survey, it seems clear that a majority of MSMA members surveyed does feel the JOURNAL MSMA performs a useful function for the medical association. Approximately 70 per cent of the repondents follow the publication regularly.

Forty per cent of the readers surveyed requested more basic, practical scientific articles and 60 per cent wanted more medical news and MSMA news. The staff considers this a clear mandate and will endeavor to publish more articles of this nature.

Overall, the Committee on Publications and the JOURNAL MSMA staff were pleased with the survey results. We recognize the fact that to survive medical journals must change with the times, hence the emphasis on medical and socioeconomic news. It is also clear that the JOURNAL MSMA is valuable because it is the only publication dealing specifically and in detail with Mississippi medical happenings and providing a ready access for publishing Mississippi physicians' work.

The original purpose of the JOURNAL MSMA was to provide a scientific and socioeconomic vehicle aimed at the specific needs of the MSMA members. This is still our goal and we welcome comments and suggestions from the membership.—NG

NEW MEMBERS

AUSTIN, WILLIAM K., JR., McComb. Born Vicksburg, MS, Dec. 30, 1944; M.D., University of Mississippi School of Medicine, Jackson, MS, 1971; internship and ENT surgery residency, same, 1971-75; elected by South Central Medical Society.

BAILEY, TERALD O., Canton. Born Hattiesburg, MS, 1949; M.D., University of Mississippi School of Medicine, Jackson, MS, 1974; interned, same, one year; elected by Central Medical Society.

BUCKLEY, ROBERT L., JR., Columbus. Born June 9, 1946, Cleveland, MS; M.D., University of Mississippi School of Medicine, Jackson, MS, 1971; interned USAF Hospital, Keesler AF Base, Biloxi, 1971-72; pediatric residency, same, 1972-74; elected by Prairie Medical Society.

COOPER, EDGAR S., Pascagoula. Born Jacksonville, NC, July 22, 1944; M.D., Tulane University School of Medicine, New Orleans, LA, 1968; interned Naval Hospital, St. Albans, NY, 1968-69; pathology residency, Naval Hospital, Philadelphia, PA, 1968-70; pathology residency, Charity Hospital, New Orleans, LA, 1973-75; elected by Singing River Medical Society.

KAHLSTORF, W. L., Tupelo. Born Greenville, MS, May 10, 1943; M.D., University of Mississippi School of Medicine, Jackson, MS, 1969; interned St. Joseph Hospital, Houston, TX, one year; ob-gyn residency, University of Mississippi Medical Center, 1972-75; elected by Northeast Mississippi Medical Society.

RENNICK, RONALD L., Poplarville. Born Edmonton, Alberta, Canada, Oct. 8, 1944; M.D., University of Alberta Faculty of Medicine, Edmonton, Canada, 1974; interned St. Paul's Hospital, Vancouver, British Columbia, Canada, one year; elected by Pearl River Medical Society.

RICCHETTI, WARREN F., Laurel. Born July 14, 1927; M.D., University of Oklahoma School of Medicine, Oklahoma City, OK, 1960; interned University Hospital, Oklahoma City, OK, one year; pathology residency, same, 1961-62; pathology residency, St. Elizabeth Hospital, Lafayette, IN, Jan. 1963-Dec. 1963; elected by South Mississippi Medical Society.

TEMPLE, VAN H., Jackson. Born Brookhaven, MS, Nov. 6, 1945; M.D., University of Mississippi School of Medicine, Jackson, MS, 1970; interned University Medical Center, Jackson, MS, one year; orthopedic surgery residency, same, 1971-75; elected by Central Medical Society.

VOGEL, B. FRANK, Hattiesburg. Born New York, NY, Jan. 19, 1909; M.D., Faculty of Medicine of University of Paris, France, 1936; interned New York Post Graduate School and Hospital, one year; psychiatric residency, New York State Psychiatric Institute, one year, psychiatric residency, Bellevue Psychiatric Hospital, 1938-39; psychiatric residency, Mental Hygiene Society of Maryland, Baltimore, MD, 1939-40; elected by South Mississippi Medical Society.



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

- Found useful in the management of vertigo* associated with diseases affecting the vestibular system.
- Can relieve nausea and vomiting often associated with vertigo.*
- Usual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.
- Also available as Antivert (meclizine HCl) 12.5 mg. scored tablets, for dosage convenience and flexibility.
- Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for nausea, vomiting and dizziness associated with motion sickness.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

FOR LONG-TERM CONTROL OF HYPERTENSION*

Serum K^+ and BUN should be checked periodically. (See Warnings Section.)



Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Warning**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

***Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F Co., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

PERSONALS

JAMES F. ARENS of Jackson and UMC was visiting professor to Vanderbilt University.

WILLIAM O. BARNETT of Jackson and UMC was guest speaker at the Ostomy Association of Jackson meeting during January. He spoke on interesting evolutionary milestones in the development of ostomies.

RICHARD BLOUNT of Jackson has been elected a vice president of the Mississippi Society for the Prevention of Blindness. Other physicians elected to the board and as voting members include: HELEN C. BERNFIELD, D. R. CALDWELL, FRED MCMILLAN, THERESA BUCKLEY, BENJAMIN MONACO, LINDSEY RISHER, LYNN D. ABERNETHY, ROBERT O. MAY, and J. G. NASSAR.

RICHARD C. BORONOW of Jackson and UMC attended an American Cancer Society junior faculty clinical fellowship subcommittee meeting.

PAUL B. BRUMBY of Lexington has been elected to serve on the Board of Trustees of the Mississippi Regional Blood Center.

WILLIAM F. CALHOUN of Natchez is new president of the Homochitto Valley Medical Society.

ROBERT CATER announces his association with GEORGE L. ARRINGTON, JR., of Meridian in the treatment of diseases of the ear, nose and throat, and facial plastic surgery, with offices located at 1413 22nd Avenue.

IRVIN H. CRONIN of Jackson announces the association of KENNETH I. CRONIN in family practice at 4304 Highway 80 West.

LOUIS A. FARBER of Jackson was appointed to the Board of Physical Therapy by former Governor Bill Waller.

HOWARD G. FREEMAN, JR., formerly of Jackson, announces the opening of his office for the practice of psychiatry at St. Joseph Community Hospital in Meridian.

JOSEPH C. GABEL of Jackson and UMC was visiting professor to the University of Cincinnati Medical Center in Ohio.

WILLIAM C. GATES of Columbus is new president of Prairie Medical Society. Secretary is JAMES H. SAMS of Columbus.

W. R. GILLIS of Jackson and UMC visited the Office of Medical Education Research and Development, East Lansing, Michigan.

JAMES R. GLEAVES has associated with the Rush Medical Group in Meridian for the practice of general surgery.

JACK C. HOOVER and JUDY FABIAN of Pascagoula were guest speakers at the Red Cross Expectant Parents Class meeting.

HAROLD K. HUDSON of Tupelo was appointed to the Mississippi Council of Advisors in Speech Pathology and Audiology by former Governer Bill Waller.

DWIGHT A. JOHNSON announces the opening of his office at 102 Hotel Street in Booneville for the general practice of medicine.

DONALD E. KILLELEA of Natchez was guest speaker for the Jan. 18 meeting of the Pathfinder Chapter, Daughters of the American Revolution in Port Gibson. He presented a visual story of the American Revolution as told through commemorative postage stamps.

FRANK L. LEGGETT of Bassfield was honored with a reception at First Mississippi National Bank for his 20 years of service to the community.

MYRON W. LOCKEY of Jackson and UMC attended the Southern Section of the Triological Society meeting in Pinehurst, NC.

TOM H. MITCHELL of Vicksburg was guest speaker at the McComb Rotary Club. He discussed PSRO.

FRANCIS S. MORRISON of Jackson and UMC attended the recent meeting of the Southern section of the American Federation of Clinical Research in New Orleans and was named president-elect of the Southern Blood Club.

DAVID C. PANKRATZ of Oxford, former dean of the Mississippi medical school, is in the process of writing the history of the school.

CHARLES R. PARKER has opened an office in Magnolia Doctor's Plaza on Alcorn Drive in Corinth for the general practice of medicine.

JOHN E. RAWSON of Jackson and UMC presented a paper at the Southern Society for Pediatric Research Convention in New Orleans.

DONALD R. RAYNER has associated with the Coastal Medical Center, P.A., for the practice of family medicine at Gateway Executive Park in Biloxi.

Richard E. Schuster of Brandon has replaced Nancy W. Burrow of Brandon on the Rankin General Hospital board of trustees.

Thomas A. Shands has associated with the Family Medical Clinic of New Albany, P.A. for the practice of general medicine.

Augustus P. Soriano has set up his general practice in DeKalb in the building adjacent to the Kemper County Hospital.

Dalton E. Spears of Raleigh has set up fulltime family practice at the Mize Clinic in Mize.

James F. Suess of Jackson and UMC attended the American Association of Directors of Psychiatric Residency Training Programs meeting in New Orleans.

Raul E. Valenzuela of Jackson and UMC participated in a vitreous retinal choroidal symposium in Miami.

Ralph T. Wicker announces the opening of his office for the practice of neurological surgery at 405 South 28th Avenue, Medical Arts Building in Hattiesburg.

W. Paul Wilcox announces the opening of his office for family practice at St. Joseph Medical Plaza in Meridian.

Ronald B. Williams, formerly of Meridian, has associated with Larry B. Morris of Macon for practice at the Morris Clinic, P.A. Dr. Williams is an anesthesiologist.

Hardy B. Woodbridge of Jackson announces the opening of his new office at Doctors Hospital Professional Building, 385 Medical Drive.

POSTGRADUATE CALENDAR

Mar. 18-20, 1976

Neurology/Neurosurgery Intensive Course
University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center, Division of Continuing Health Professional Education with partial support from Mississippi Regional Medical Program

Coordinators:
Robert D. Currier, M.D., professor of medicine and chief of the division of neurology, the University of Mississippi School of Medicine
Glen C. Warren, M.D., clinical assistant professor of neurosurgery, the University of Mississippi School of Medicine

This course will deal with the problems primary care physicians encounter most often in their practices. Participants will discuss head injury, the dizzy patient, headaches, epilepsy, sciatica, strokes, and tumors in relation to adult and pediatric neurology and neurosurgery.

Mar. 22-26, 1976

Pediatrics Intensive Course
University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center, Division of Continuing Health Professional Education with partial support from Mississippi Regional Medical Program

Coordinator:
J. M. Montalvo, M.D., professor of pediatrics, the University of Mississippi School of Medicine

Course content includes special problems in newborn care; neurology, with a special emphasis on convulsive seizures, meningitis, and head trauma; care and problems of the adolescent; allergy; hematology; oncology; pediatric emergencies; cardiology; radiology; fluid and electrolytes; nephrology; endocrinology; inhalation therapy; pediatric surgery; and orthopedic problems in children.

Mar. 24-27, 1976

American College of Physicians Hematology/Oncology Conference
Hilton Hotel, Jackson

Sponsored by the University of Mississippi Medical Center Division of Hematology, Oncology, and Continuing Health Professional Education, and the American College of Physicians

Coordinator:
Francis S. Morrison, M.D., associate professor of medicine and director of the division of hematology, the University of Mississippi School of Medicine

Question and answer sessions will follow a series of scientific lectures, and registrants will participate in general discussions. Panel presentations will focus on solid tumors, hematologic malignancy, supportive care, and hemolytic disease.

April 5-9, 1976

PULMONARY MEDICINE INTENSIVE COURSE
University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center, Division of Continuing Health Professional Education with partial support from MRMP

Coordinators:
Joe R. Norman, M.D., professor of medicine and director of the pulmonary division, the University of Mississippi School of Medicine
A. Wallace Conerly, M.D., assistant professor of medicine, University of Mississippi School of Medicine

Routine pulmonary evaluation and pulmonary function testing will be included in this one-week course. Lectures will cover occupational lung diseases and pulmonary impairment, non-thoracotomy diagnosis and techniques, arterial blood gases, chronic airways obstruction, bronchitis, emphysema, reversible airways obstruction, interpretation of pulmonary function studies, pneumonias, endoscopy, transnasal fiberoptic bronchoscopy and lung biopsy, pulmonary thromboembolism, modern management of pulmonary tuberculosis, and sarcoid and infectious granulomas. Registrants will round daily.

April 13, 1976

MISSISSIPPI THORACIC SOCIETY MEETING
University Medical Center, Jackson

Sponsored by the Mississippi Thoracic Society, Mississippi Lung Association, the University of Mississippi School of Medicine, and the University Medical Center Division of Continuing Health Professional Education

Coordinator:
Walter Treadwell, M.D., associate professor of family medicine, the University of Mississippi School of Medicine

Participants will receive AAFP credit and AMA Physician's Recognition Award credit, Category I.

April 19-23, 1976

NEPHROLOGY INTENSIVE COURSE
University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center, Division of Continuing Health Professional Education with partial support from MRMP

Coordinator:
John D. Bower, M.D., associate professor of medicine and director of the artificial kidney unit, the University of Mississippi School of Medicine

This clinically oriented course will emphasize the reversible and treatable forms of kidney disease.

April 30, 1976

ANNUAL KIDNEY DISEASE SEMINAR
University Medical Center, Jackson

Sponsored by the Kidney Foundation of Mississippi, the University of Mississippi School of Medicine Departments of Medicine, Surgery (Urology), and Pediatrics, and the University Medical Center Artificial Kidney Unit and Division of Continuing Health Professional Education

Coordinator:
W. Lamar Weems, M.D., professor of surgery (urology) and chief of the division of urology, the University of Mississippi School of Medicine

Participants will focus on urinary tract infections.

FUTURE CALENDAR

May 3-6, 1976

MISSISSIPPI STATE MEDICAL ASSOCIATION

June 3-4, 1976

EMERGENCY CARE COURSE

Intensive courses are eligible for AMA Physicians Recognition Award Category I credit. Enrollment is limited, and applications are accepted in the order received. All correspondence about intensive and other courses should be addressed to Continuing Health Professional Education, University Medical Center, 2500 North State Street, Jackson, MS 39216.

Medico-Legal Briefs

$175,000 AWARDED TO PARENTS FOR OUTRAGEOUS CONDUCT BY HOSPITAL

A trial court awarded $175,000 in compensatory and punitive damages for "outrageous" conduct in displaying to a mother the body of her premature child who had died shortly after birth and had been placed in a gallon jar of formaldehyde. The award was upheld by a Tennessee appellate court.

The parents brought an action against the patient's physician and the hospital where the child was born. They alleged that the hospital and physician had breached a contract to bury the child and had committed outrageous conduct. When the patient had visited her physician for her six weeks checkup, she noted a pathologist report attached to her medical chart.

The report stated that the fetus was past the fifth lunar month in development and hospital rules and state law prohibit disposal of it as a surgical specimen. Shocked at the report, she asked the physician what it meant. She had thought that the body had been disposed of by common traditions of human dignity. The physician instructed his nurse to take her to the hospital. There she was led to a freezer and was handed a gallon jar of formaldehyde with the discolored and shrivelled body of her child floating inside.

A jury returned verdicts for $175,000 in compensatory damages to the patient and her husband and $125,000 in punitive damages. Motions for a new trial were made, but the court denied them subject to a reduction in damages to a total of $175,000. The patient and her husband appealed.

On appeal, the Tennessee court disposed of several claims of error. The evidence supported a finding that the hospital had agreed to properly handle the body but had mishandled it. The hospital's conduct in displaying the fetus to the mother was outrageous conduct that caused her severe emotional distress. The physician was not liable for damages since he was not aware of the preservation of the fetus, nor did he participate in the display of the fetus. The $100,000 in compensatory damages was not excessive considering the psychiatric treatment which the patient was undergoing.

The appellate court reversed the judgment against the physician but affirmed the judgment against the hospital.—*Johnson v. Woman's Hospital,* 527 S.W.2d 133 (Tenn. Ct. of App., Feb. 2, 1975; cert. denied, Tenn. Sup. Ct., Aug. 11, 1975).

MS Blue Cross-Blue Shield Announces Building Plans

Blue Cross-Blue Shield of Mississippi, Inc. has announced plans to construct a new building on Lakeland Drive in Rankin County which will house all program operations except Medicare and Medicaid. Medicare and Medicaid will be housed in the organization's present building on Woodrow Wilson Drive in Jackson.

Beginning as a one room operation on North President Street with three employees in 1947, the Mississippi Blue Cross-Blue Shield Plan now reports a total work force of 645 employees located at eight different locations in Jackson. In 1974 the plan paid some $231 million in claims on behalf of 1.2 million Mississippians.

Dr. Clyde Watkins Assumes New TB Post

Dr. Clyde Watkins has assumed the duties of medical consultant in the SBH Tuberculosis Control Unit, according to Dr. Alton B. Cobb, State Health Officer.

Dr. Watkins will provide medical direction for development of the statewide program for treatment of tuberculosis in selected community hospitals. Prior to his current assignments he served as superintendent administrator of the Mississippi State Sanatorium for 30 years.

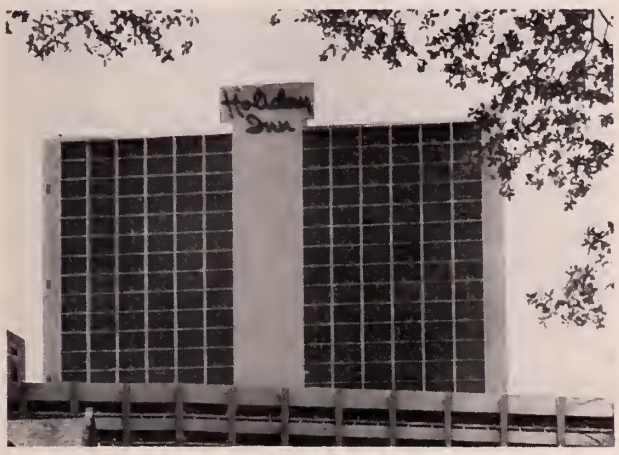
According to Dr. Cobb, the Board of Health is presently organizing and implementing a network of cooperative community hospital-health department treatment programs for tuberculosis. The Delta Medical Center in Greenville and the Southwest Mississippi Regional Medical Center in McComb are providing inpatient services for tuberculosis patients in those areas. Four or five of the planned regional hospitals slated to participate in the program should be in operation before July 1976.

"We believe that treatment of tuberculosis at the community level will maintain and strengthen the public health control program," Dr. Cobb said. "It should also provide quality comprehensive service to the patient nearer his home, and reduce the costs to the taxpayers for an essential public health program."

MSMA Annual Session Returns to Jackson; Headquarters Is New Holiday Inn Downtown

The 108th Annual Session returns to Jackson for the first time since 1968. Convention headquarters will be the all new 23-story Holiday Inn Downtown. Located in the heart of Jackson's downtown area, only a quarter mile from the Capitol, the hotel tower affords spectacular views of the city from its 360 guest rooms that include 16 suites.

The entire second floor is devoted to Convention Center facilities which include 15 meeting rooms to accommodate groups of from 10 to 1,000 persons. Each room has its own individually controlled heating/air conditioning and sound systems. Escalators and four high-speed elevators combine to facilitate rapid movement from the lobby below or the guest tower to the convention center.



The new Holiday Inn Downtown adds its 23-story tower to the changing Jackson skyline.

The hotel features the Boll Weevil Lounge and the Plantation Dining Room and is easily accessible to other restaurants and clubs in the city. There is a covered walkway to the Deposit Guaranty Plaza which affords banking and shopping opportunities.

Parking facilities include 400 covered spaces on the hotel property, which are complimentary to hotel guests, and 600 indoor spaces in the adjoining and connected Jackson Municipal Garage; however, parking spaces will still be at a premium for a large convention such as MSMA. Some spaces will be available on the street and a nearby parking garage is that of the Downtowner Hotel with entrances on Pearl Street.

For reservations at the headquarters hotel, contact Mrs. Barbara Shelton at MSMA, P.O. Box 5229, Jackson, MS 39216 or call 354-5433.

The complete annual session program will be published in the April issue of the JOURNAL MSMA along with preliminary House of Delegates reports.

Central Medical Society Meets With Solons

Central Medical Society conducted a special "Legislative Dinner" for members of the Mississippi Legislature from the society's area on Feb. 2.

MSMA's medical liability legislative program and other legislation covering Medicaid reimbursement, a medical examiner's office and insurance coverage of psychiatric care were discussed at the meeting.

Conducting the program were Drs. Max L. Pharr, Ellis M. Moffitt, Julian C. Henderson, Martin B. Harthcock, Jr., Jim G. Hendrick, O. W. Conner and James E. Ruff.

St. Dominic Medical Staff Officers Announced

New officers for 1976 have been elected by the Medical and Dental Staff of St. Dominic-Jackson Memorial Hospital. Serving as Chief of Staff for 1976 will be Dr. Richard L. Blount. He will be assisted by Chief-Elect, Dr. Thomas C. Turner, and Secretary, Dr. James N. McLeod.

Dr. Paul Goode was elected Chief of General Practice and Dr. Lewis D. Lipscomb, Chief of Ob-Gyn. Also serving on the executive committee are Drs. H. Richard Johnson, Past Chief; C. E. Wallace, Chief of Medicine; Eva Linn Meloan, Chief of Pediatrics; J. E. Ruff, Chief of Psychiatry; and W. H. Merrell, Chief of Surgery.

DEATHS

FENSTERMACHER, RICHARD H., Vicksburg. Born Lebanon, PA, 1912; M.D., Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA, 1937; interned The Reading Hospital, Reading, PA, one year; pathology residency, same, 1938-40; pathology fellowship, Mayo Foundation, July 1940-Jan., 1943; died Jan. 7, 1976, age 63.

O'MARA, WILLIAM E., Carthage. Born Jackson, MS, Dec. 8, 1945; M.D., Tulane University School of Medicine, New Orleans, LA, 1971; interned University Medical Center, Jackson, MS, one year; general surgery residency, V.A. Hospital, Memphis, TN, one year; died Jan. 15, 1976, age 31.

BRIEF SUMMARY OF
PRESCRIBING INFORMATION
ANTIMINTH® (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017



eliminates Pinworms and Roundworms with a single dose

- **Single dose effectiveness against both pinworms and roundworms**—The only single-dose anthelmintic effective against pinworms *and* roundworms.
- **Nonstaining**—to oral mucosa, stomach contents, stools, clothing or linen.
- **Well tolerated**—the most frequently encountered adverse reactions are related to the gastrointestinal tract.
- **Economical**—a single prescription will treat the whole family.
- **Highly acceptable**—pleasant-tasting caramel flavor.
- **Convenient**—just 1 tsp. for every 50 lbs. of body weight. May be taken without regard to meals or time of day.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Please see prescribing information on facing page. NSN 6505-00-148-6967

Antiminth® ORAL SUSPENSION
(pyrantel pamoate) equivalent to 50mg pyrantel/ml

Tri-State Heart Assembly Planned

The heart associations of Louisiana, Arkansas and Mississippi are sponsoring their annual Tri-State Scientific Sessions for Physicians to be held at the Monteleone Hotel in New Orleans on May 20-22, 1976, entitled "Cardiology '76."

The program highlights topics of current cardiovascular interest and is directed to family physicians, internists, cardiologists and cardiovascular surgeons. Dr. Roland Robertson of the University of Mississippi Medical Center is serving as a member of the planning committee.

The program is approved for 15½ elective hours by the American Academy of Family Physicians. Registration fees are $130 for heart association members and $150 for non-members.

For reservations and further information, contact John Paul, American Heart Association-Louisiana, Inc., Box 19122, New Orleans, LA 70179.

Dr. Alton Cobb Receives New Appointment

Mississippi State Health Officer Dr. Alton B. Cobb has been named to the executive committee of the Association of State and Territorial Health Officials.

The ASTHO was organized in the 1930's and is comprised of directors of public health agencies from the 50 states as well as the U. S. territories. ASTHO is the official organization which jointly with the Department of Health, Education, and Welfare develops public health policies and priorities in the nation.

The executive committee is made up of eight public health officials who set policy for the organization and represent the organization in appearances before Congressional committees and in relationship with other national health organizations.

Dr. Cobb was appointed state health officer on July 1, 1973. He had previously served as director of the State Medicaid Commission and as director of Comprehensive Health Planning in Mississippi.

MSMA President Testifies Before Legislature

MSMA president, Dr. Jack A. Atkinson of Brookhaven, recently appeared before committees of the Mississippi legislature to discuss the association's position on drug substitution and creation of a joint underwriting association to provide professional liability insurance to physicians and hospitals.

In a full blown hearing before the Senate Insurance Committee chaired by Senator Perrin Purvis of Tupelo, Dr. Atkinson discussed the medical insurance crisis in Mississippi and urged passage of SB 2310 authorizing the State Insurance Commissioner to establish a joint underwriting association in Mississippi if no companies were available to provide professional liability insurance.

In another hearing before a subcommittee of the House Committee on Public Health, chaired by Rep. Bunky Huggins of Greenwood, Dr. Atkinson urged defeat of HB 259 and similar proposals to permit substitution for a physician's prescription stating that such proposals raised questions of liability, bioequivalency of drugs and cost savings that could not be satisfactorily answered.

EMCU Serves Mississippi Legislature



Senator Jim Noblin of Jackson gets his blood pressure checked by the Doctor of the Day, Dr. Hardy B. Woodbridge of Jackson, in the MSMA-sponsored Emergency Medical Care Unit at the Mississippi Capitol building. EMCU nurse Mrs. Mavis Barlow assists the doctors of the day who volunteer to serve the legislators and Capitol staff during the Legislative session. The association has sponsored the care unit for the past eleven years.

UMC Surgical Forum Is March 11-13

A surgeon who has contributed to more than 300 scientific publications and movies, an internationally known lecturer and writer, and the chairman of the University Department of Surgery, the General Infirmary, Leeds, England, headline Surgical Forum III.

The University of Mississippi Medical Center Postgraduate Surgical Forum III is scheduled Mar. 11-13 at Holiday Inn Downtown in Jackson.

Among the 12 internationally known surgeons who will join Medical Center faculty as program participants are Dr. Lloyd M. Nyhus, Dr. David C. Sabiston, Jr., and Professor J. C. Goligher.

Dr. Nyhus is Warren H. Cole professor of surgery and head of the department at Abraham Lincoln School of Medicine, the University of Illinois Medical Center, Chicago. He has contributed to or authored more than 250 scientific articles, 60 books, and six movies and has lectured throughout the world—in Japan, Germany, Greece, Australia, South Africa, Ireland, and several other countries besides the United States.

Editor-in-chief of *Review of Surgery* since 1967, Dr. Nyhus is on the editorial boards of seven surgery journals, including *Gastrointestinal Radiology, American Surgeon,* and *Scandinavian Journal of Gastroenterology.*

Dr. Sabiston, James B. Duke professor of surgery and chairman of the department, Duke University Medical Center, is also a recognized writer and lecturer, with contributions to 193 publications and lectures in seven foreign countries.

Dr. Sabiston is immediate past chairman of the American College of Surgeons Board of Governors. He is editor of *Annals of Surgery* and is on the editorial boards of *The Journal of Cardiovascular and Thoracic Surgery, Circulation, Annals of Clinical Research,* and *Archives of Surgery.*

Professor Goligher, who has chaired the surgery department at the Leeds General Infirmary since 1955, is primarily interested in surgery of the stomach and intestinal tract. Original contributions in that area include the textbook *Surgery of the Anus, Rectum, and Colon.*

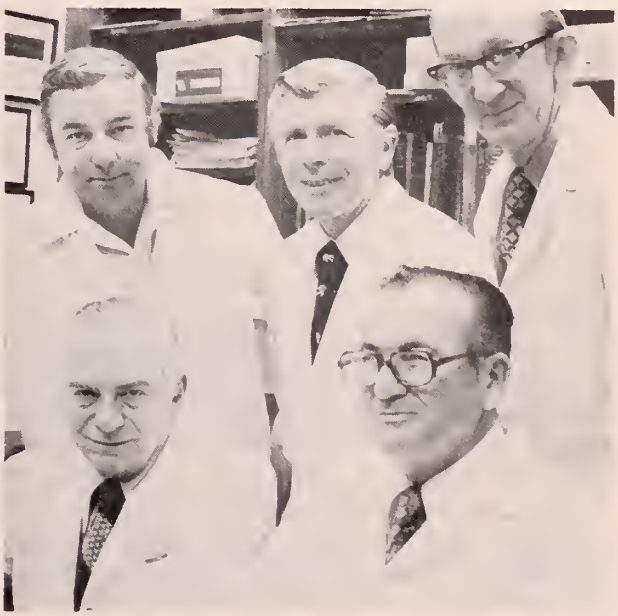
President of the British Society of Gastroenterology, Professor Goligher is a member of the Council of the Royal College of Surgeons of England and of the Association of Surgeons of Great Britain and Ireland, which he served as president in 1972.

Other guest faculty members for Surgical Forum III are Dr. Curtis P. Artz, Dr. John M. Braasch, Dr. George L. Jordan, Jr., Dr. Marshall J. Orloff, Dr. William H. ReMine, Dr. Charles G. Rob, Dr. John L. Sawyers, Dr. James C. Thompson, and Dr. Robert Zeppa.

Lectures and panel discussions will focus on vascular, general, stomach, and biliary tract surgery.

The medical school Department of Surgery and UMC continuing education division sponsor the annual event. Attendance is by invitation, and advance registration is required.

EKG Course Draws State Physicians



Physicians who took the intensive refresher training in electrocardiography at the University of Mississippi Medical Center in Jackson included, seated, from left, Dr. E. E. Ellis of Laurel, Dr. L. Z. Broadus of Purvis; and, standing, Dr. L. Todd Cross of Gadsden, AL, Dr. Durward Blakey of Jackson, and Dr. Ben J. Moore of Batesville. Others who took the course were Dr. Thomas Russell Shaw of Lucedale, Dr. Joe B. Holden of Crowley, LA, Dr. W. B. Larkin of Bude, Dr. Wayne Hughes of Wiggins, and Dr. Charles Pruitt, III, of Magee. The UMC Division of Continuing Health Professional Education sponsored the week-long session with Mississippi Regional Medical Program support.

MFMC Reports PSRO Implementation

The Mississippi Foundation for Medical Care, Inc.-Professional Standards Review Organization (PSRO) reports that the medical staffs of almost half of the state's general hospitals have fully implemented utilization and quality review procedures and are on binding review which indicates attainment of review standards. The hospitals represent 60 per cent of the state's total of general hospital beds.

At this time the MFMC-PSRO is working with additional hospital medical staffs to implement review procedures and these hospitals represent 30 per cent of the state's general hospital beds.

The MFMC was fully funded as a Professional Standards Review Organization in June 1975. The MFMC-PSRO is governed by a 23-member board of which 20 members are physicians from throughout the state. Dr. Tom H. Mitchell of Vicksburg serves as Executive Director of the MFMC.

Health Planning Designation Brews

Mississippi has two applicants for a "Health Systems Agency" and two state agencies being considered as a "State Planning and Development Agency" under requirements of Public Law 93-641, the National Health Planning and Resources Development Act of 1974.

In implementing Public Law 93-641 the Secretary of HEW set Jan. 19, 1976, as the initial date for submission of applications for funding as Health Systems Agencies. Two private Mississippi corporations submitted applications on that date. One of the applicants, the Mississippi Health Improvement Corporation, Inc., evolved from the Mississippi Regional Medical Program. The other applicant, the Mississippi Health Systems Agency, Inc., has as its president and motivating force the director of the Mississippi Optometric Association. Only one of the applicants can be selected.

On the state level, several bills are now pending in the Mississippi legislature to establish either the Governor's Office of Comprehensive Health Planning or the Mississippi State Board of Health as the "State Planning and Development Agency" under Public Law 93-641.

Public Law 93-641 was passed by Congress in the closing hours of the 93rd Congress after several years of discussion over how to redirect and make more meaningful the functions of the Comprehensive Health Planning, Regional Medical and Hill-Burton programs. It has been described by both proponents and opponents as the most far-reaching health legislation enacted by Congress since passage of Medicare/Medicaid in 1965.

Rural Health Is Emphasized

MSMA will join with other concerned organizations in participating in "National Rural Health Week" designated by Congress for April 4-7, 1976.

Originally conceived by the Council on Rural Health of the AMA and actually supported by the American Dental Association, American Hospital Association and numerous other national organizations, the purpose of "National Rural Health Week" is to stimulate a new awareness of the critical and unique health problems facing citizens in the rural areas of our country.

The week will emphasize programs to address such health care needs of rural areas as emergency medical services, health manpower recruitment, health education and development of health care facilities. Action kits will be furnished to community leaders, local health agencies and others interested in promoting local rural health programs.

Mississippi's congressional delegation joined in sponsoring bills to designate a "National Rural Health Week."

Lung Association Supports Pulmonary Fellows

To help prevent and control lung disease and pulmonary problems in this state, the Mississippi Lung Association supports training for pulmonary medicine fellows at the University of Mississippi Medical Center.

Dr. James Griffith and Dr. Charles Parkman are current MLA fellows, and three other young physicians will begin pulmonary medicine fellowships this year.

Half the patients they see at UMC have such smoking-related diseases as chronic bronchitis, em-

physema, lung cancer. Some have non-smoking-related diseases, such as asthma or tuberculosis.

In addition to caring for patients, the pulmonary medicine fellows help teach medical students, interns, and residents; work in the pulmonary laboratory; and do some research. Each completed three years of postgraduate training in internal medicine before beginning the two-year pulmonary fellowship.

"The program is individually structured," Dr. Parkman said. "It's set up so that each fellow can learn about and contribute to pulmonary medicine while he specializes in his particular area of interest —patient care, laboratory instrumentation, or research."

The Mississippi Lung Association has sponsored the pulmonary medicine fellowship at UMC for five years. The organization also supports a Christmas Seal professor of respiratory disease at UMC, finances special Mississippi medical research-education program, and supports workshops for physicians, inhalation therapists, nurses, and allied health personnel.

Thoracic Case Conference Held in Biloxi



The 20th Annual Thoracic Case Conference was held Jan. 23-24 in Biloxi. Dr. John R. Williams (left) of Greenville, president of the Mississippi Thoracic Society; Dr. Benjamin Burrows, director of Division of Respiratory Sciences, University of Arizona College of Medicine; and Dr. Roland B. Robertson, Jr. of Jackson, program chairman for Mississippi, were among featured speakers for the two-day event. Dr. John D. Morgan of McComb was also on the program. Lung associations and thoracic societies of Alabama, Louisiana, and Mississippi sponsor the continuing series of special interest to thoracic specialists.

Medical Center Has Visiting Faculty

Dr. Gunnbjorg A. Lindseth has been appointed to the University of Mississippi Medical Center faculty as visiting assistant professor of pathology.

Vice Chancellor Dr. Norman C. Nelson announced the appointment, effective Mar. 15, following action of the Board of Trustees of Institutions of Higher Learning.

Dr. Lindseth comes to UMC from the Radium Hospital, Oslo, Norway. She was previously with the University of Minnesota as a fellow and then an instructor.

After earning her M.D. degree from the University of Oslo, Dr. Lindseth did residencies at Sorvaranger Hospital, Kirkenes, Norway, at Radium Hospital, Oslo, and at Midway Hospital, St. Paul, Minn.

She also completed a fellowship at the University of Maryland, where she served as an instructor.

UMC Researcher Gets ACS Fellowship

A University of Mississippi Medical Center scientist has been awarded a two-year fellowship grant from the American Cancer Society (ACS) to study the infection process of the herpes virus group.

Dr. George Perry Allen, postdoctoral fellow in microbiology at UMC, will work under the direction of microbiology department chairman Dr. Charles C. Randall.

Recent research has implicated the viruses as a cause of cervical cancer in women, Dr. Allen said.

In conducting basic research on the biology and chemistry of the virus group, Dr. Allen will study its reproduction properties, how it enters body tissue, how it kills cells or transforms normal cells into cancerous ones.

During the first phase of research, he will examine the enzymes produced by the virus and needed for its reproduction.

"We're looking for a way to stop the activity of these enzymes without interfering with the normal cellular enzyme action," he said. "It may then be possible to control the infection process by some agent which inhibits the enzyme activity."

Family Practice Board Announces Next Exam

The American board of family practice announces the next certification examination will be given Oct. 30-31, 1976. The two day written examination will be held in seven cities geographically distributed throughout the United States.

Information regarding the examination may be obtained by writing: Dr. Nicholas J. Pisacano, Executive Director and Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Lexington, KY 40506.

It is necessary for each physician desiring to take the examination to file a completed application with the board office. *Deadline for receipt of applications in this office is June 15, 1976.*

Ford Proposes Change In Health Funding

President Ford's proposal to consolidate Medicaid and 15 other health programs into a single $10 billion block grant would have a profound effect on Mississippi and other states.

The block grant proposal contained in Ford's "Financial Assistance for Health Care Act of 1976" would eliminate the categorical grants targeted for federal support of such programs as Medicaid, health planning, maternity and child health, family planning and emergency medical services.

Mississippi and other states would no longer be required to provide matching funds for the programs. Each state would set its own spending priorities based upon federal requirements that 90 per cent of the funds received by a state must be spent on personal health care services, five per cent must be spent on community and environmental health activities and the remaining five per cent may be spent on other health activities such as state and local health planning.

The consolidation program would be phased in to protect people covered under affected programs and would insure that no state received less funding in fiscal 1977 than it did in 1976. Thereafter, funds would be distributed to each state based on its low income population and per capita income with no state receiving a yearly increase of more than 20 per cent or loss of more than 5 per cent.

Some 1600 positions and numerous volumes of rules and regulations in the Department of HEW would also be eliminated under the proposed consolidation program.

Family Physicians Learn To Be Preceptors

Family physicians who will help teach Mississippi medical students about hometown practice are preparing for their assignments in 10 regional workshops.

Begun in February, the five-hour sessions are for physicians who want to serve as preceptors in the Department of Family Medicine at the University of Mississippi Medical Center.

Each preceptor takes one or more third or fourth year medical students as a member of his team for three weeks, helping the student learn to provide health care in the office, home, hospital, or nursing home. Students get to know the communities where they may someday choose to locate.

Offered first as a senior medical student elective course, beginning in June, preceptorships will be required for all juniors, with a second assignment available as a senior elective.

Preceptor workshops are scheduled Mar. 10 at Oxford; Mar. 24, Natchez; April 8, Greenville; April 15, Starkville; April 21, Biloxi; April 29, Meridian; May 13, Gulfport; and May 20, Jackson. February offerings were at Greenwood and Laurel.

Family medicine fulltime faculty members teach the sessions, discussing needs and requirements for the preceptorship. Divided into small workshop groups for lectures and panel and audiovisual presentations, participants cover most frequently asked questions to learn how to teach students about continuous, comprehensive, family-centered care.

Each session features the same material; so physicians may attend the workshop of their choice, preferably in their own region. No registration fee is charged.

Enrollment for each workshop is limited, with applications accepted in the order received. Advance registration should be addressed to Department of Family Medicine, University Medical Center, 2500 North State Street, Jackson, MS 39216.

The family medicine department and continuing education division sponsor the sessions with funding from a DHEW Public Health Service grant.

Stennis Proposes Retirement Tax Relief

Representative John Hampton Stennis of Jackson has introduced a bill in the Mississippi legislature which will correct an obvious inequity in present state tax laws that prohibit individuals from deducting contributions to retirement plans.

House Bill 555 as introduced by Stennis and referred to the House Ways and Mean Committee chaired by Representative Butch Lambert of Tupelo would conform Mississippi Income Tax Law to its federal counterpart in the area of contributions to qualified pension and annuity plans.

Individual contributions to Keogh and Individual Retirement Accounts are now deductible under federal tax laws but not under Mississippi laws. MSMA is joining other interested groups in strongly supporting passage of House Bill 555.

UMC Announces Newborn Center Art Contest

Entry deadline for the first University of Mississippi Medical Center Newborn Center art competition is April 15.

Using art to increase state awareness of the importance of maternal-infant health care, the UMC Newborn Center is sponsoring the contest in cooperation with the March of Dimes.

The contest is open to all Mississippi artists, and health care professionals are especially encouraged to enter.

Each entry must illustrate some aspect of maternal and infant care or the artist's perception of a mother and baby.

Three divisions of competition are high school, college and university, and adult. One purchase award will be offered in each division: $75 in high school category; $150, college and university; and $200, adult. Additionally, three works in each category will be selected for an honorable mention citation.

One work selected for a purchase award will be designated "best in show" and used as the illustration for the Newborn Center Christmas card in 1976. Competition entries will be displayed and contest winners announced at a formal showing at the Medical Center in June.

Contest brochures and entry forms may be obtained from Art Competition, Department of Special Services and Campus Relations, University Medical Center, 2500 North State Street, Jackson, MS 39216.

Internists Study Infectious Diseases

The American College of Physicians will sponsor a three-day postgraduate course entitled "Current Concepts of Clinical Infectious Diseases" on April 21-23, 1976, in Charlottesville, VA. The course will be held in conjunction with the University of Virginia School of Medicine.

The course will be devoted to the management of common infectious problems and to an appraisal of advances in the field of infectious disease and immunology. Discussions will include the selection and use of antibiotics, the role of normal flora in disease, venereal disease and relevant parasitic infections.

The American College of Physicians postgraduate courses have been approved by the American Medical Association Advisory Committee on Continuing Medical Education for Category 1 credit.

Director of the Charlottesville postgraduate course is Dr. Edward W. Hook.

Southeastern Surgical Congress Set

The 44th Annual Assembly of the Southeastern Surgical Congress will be held Mar. 14-18, 1976, in the New Orleans Marriott Hotel.

On the doctors' program, new and significant developments in surgery will be discussed by six well-known guest speakers and by many of the prominent members of the Southeastern Surgical Congress—second largest American surgical association—and by other speakers.

The program will include papers on gastrointestinal surgery and vascular surgery, and there will be a Thursday morning session on management of breast cancer featuring nationally known advocates of both radical and non-radical procedures. Among the breast-cancer panelists will be Marvella Bayh, wife of U.S. Senator Birch Bayh.

A special feature of the 1976 assembly will be a postgraduate course Sunday Mar. 14, concluding on Tuesday afternoon, Mar. 16, on "Cancer of the Colon."

Blood Banks Group Meets in 1976

The 18th Annual Meeting of the South Central Association of Blood Banks will be held Mar. 23-25, 1976, at the Houston Oaks Hotel, Houston, Tex.

For additional information, please contact: Floy Bleker, Executive Secretary, South Central Association of Blood Banks, 4300 North Lamar Boulevard, Austin, TX 78756.

Emotional Problems Management Course Offered

Mini-residencies (one, two and three weeks) for medical and surgical practitioners in "Office Management of Emotional Problems" are presented monthly by the University of Kentucky Medical Center, Department of Outpatient Psychiatry, in Lexington.

The courses are eligible for 40 units/week of Continuing Education Credit. Tuition is $350.00 per week.

For further information, contact: Dr. Maxie C. Maultsby, Jr., Office of Continuing Education, University of Kentucky Medical Center, 800 Rose Street, Lexington, KY 40506.

Arts Festival Set for April

Center city traffic will come to a standstill in one of the south's fastest growing metropolitan areas when the 1976 Mississippi Arts Festival kicks off its "Capitol Street Festival" on April 23.

The 13th annual state arts spectacular moves from its traditional fairgrounds home to downtown Jackson's historic Capitol Street where traffic will be blocked off for the opening weekend of the festival. Billed as a special salute to Mississippi's heritage and the nation's bicentennial, the week-long series of performing arts attractions, exhibits and seminars will continue through May 3 in the "spaces and places" along the historic street and its connecting north-south arteries.

"The 1976 festival will be a 'must' for history buffs during our bicentennial year," said Mrs. Chandler Clover, MAF production committee chairman.

"If all goes as planned, the 'Capitol Street Festival' should be one of the most diverse bicentennial offerings in the south this year," she said. "It will be a broad statement—both artistic and entertaining—celebrating our country's natural, historical and cultural heritage."

The festival will begin with special ceremonies from the steps of the Old Capitol Museum and a parade down Capitol Street. From then on, most of downtown Jackson will open its doors for festival goers.

There'll be art shows up and down the street—and craftsmen working in many. Smith Park will be the scene of performing arts attractions throughout the opening weekend, with a "street dance" planned for the public square on Friday night. At the Old Capitol, there'll be special exhibits, including one on historic chairs—"the seat of American Invention."

The Freedom Train will be in Jackson for festival week, and the state's Natural Science Museum plans a special multi-media presentation on natural history. There'll be at least three special seminars—featuring noted writers Margaret Walker Alexander, Wyatt Cooper and Katherine Tucker Windham—and a new downtown walking tour of the city. The Jackson Symphony Orchestra will play its traditional youth concerts for state elementary youngsters and also take the Smith Park stage for special festival concert on Sunday afternoon, April 25.

There'll be a nominal fee charged for some of the special exhibits and shows, and tickets will be required for the festival's "headliner" night performances in city auditorium and at the coliseum, but most of the attractions will be free.

"We believe the festival this year," Mrs. Clover said, "will offer something for all ages—from three to 103. We hope that all Mississippians will plan to be with us in Jackson for this special salute to our state and nation."

Many physicians' wives are involved in preparations for the arts festival. Among those working this year are Mrs. Tate Thigpen, MAF committee treasurer; Mrs. Richard L. Blount, festival youth concert chairman; and Mrs. W. H. Aden, who is in charge of children's events for the annual arts spectacular.

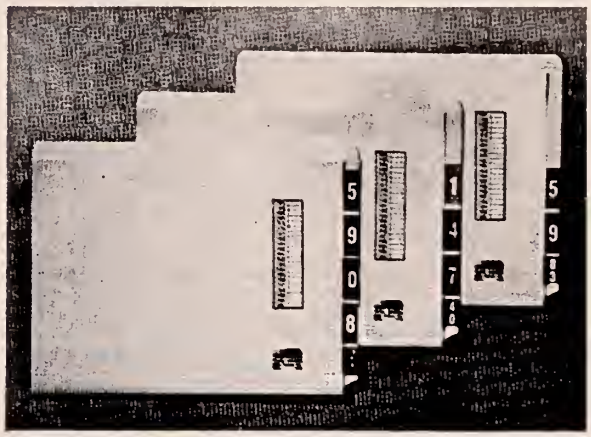
CLASSIFIED

FOR SALE OR LEASE—Doctor's Office Building —vicinity of Memorial Football Stadium and across from University Hospital. Modern clinic built for X-ray and laboratory and 3 or 4 doctors. Nine exam rooms, four offices. 3300 square feet. Ample parking. Contact 969-7720.

FULL-TIME ER PHYSICIAN—for modern, expanding, fully-accredited 467-bed regional medical center with low malpractice ins. rates, salary and fringes negotiable, progressive staff with specialty back up. Excellent schools, college facilities, cultural activities, recreational activities. Contact Dan S. Wilford, Adm., North Mississippi Medical Center, 830 South Gloster St., Tupelo, MS 38801. (601) 842-3632.

WHY OUR COLOR CODED FILING SYSTEM?

REDUCES FILING TIME
ELIMINATES MIS-FILES
NO NEED TO REPLACE YOUR PRESENT FOLDERS



PRINTING — OFFICE DESIGN, FURNITURE & SUPPLIES

Mississippi Stationery Company
277 East Pearl Street – Jackson, Mississippi 39201

FOR MORE INFORMATION
CALL COLLECT (601) 354-3436

Index to Advertisers

Blue Cross and Blue Shield of MS 8
Burroughs Wellcome Co. 12

Canton Exchange Bank 11
Coca-Cola 17

Dow Pharmaceuticals 72A, 72B, 72C, 72D

For Sale or Lease 19
Fulltime ER Physician 19

Hill Crest Hospital 10
Hyrex-Key Pharmaceuticals 15

Eli Lilly and Co. ..... front cover

Mead Johnson Laboratories 18
Mississippi Stationery Co. 19

Pharmaceutical Manufacturers Association 6, 7
Premier Printing Co. 73

Roche Laboratories .. second cover, 3, third and fourth covers
Roerig, A Division of Pfizer Pharmaceuticals . 76A, 82, 83

Smith Kline and French 76B
Systemedics/AMS 14

Volunteers of America 16

Wayne Medical Laboratory, Inc. 17

Thomas Yates and Co. 4

LIBRARY
MAR 18 1976
NEW YORK ACADEMY OF MEDICINE

IN CONCLUSION

The AMA will help launch and finance a National Advisory Committee on Ethics as a public service. The formation of such a committee, which will function independently, was approved by the Board of Trustees at its October 1975 meeting. Fred T. Allen, Chairman of Pitney Bowes Corp. and head of the committee, said, "Our purpose is to call attention to the importance of the ethical underpinnings of business, law, medicine, journalism, education -- in fact, our whole society. Without a pervasive pattern of individual honesty a free society cannot function."

A greater than 99 percent success rate has been reported in psoriasis patients treated with a combination of drugs and ultraviolet radiation by Dr. Isaac Willis, associate professor of dermatology at Emory University in Atlanta. His method involves the topical application of mainly two drugs -- anthralen and methoxsalen. In the last four years he has treated more than 200 psoriasis patients. Most have been either markedly improved or gone into long-range remission. Search for a permanent cure continues.

The Medical College of Pennsylvania is compiling a comprehensive bibliography of literature about women physicians. Funded by a National Library of Medicine grant, the bibliography will be published by Scarecrow Press, Inc. of Metuchen, NJ. All identifiable books, periodical articles, historical and contemporary reports, authored by women MDs, material on women physicians, specific or in general, will be included. Information in these categories should be sent to Sandra Chaff, Library of Medicine, Medical College of Pennsylvania, 3300 Henry Ave., Philadelphia 19129.

"X-Ray Examinations: A Guide to Good Practice", a new educational film that surveys proper procedures and safe practices to help reduce potential hazards of radiation, is available for showing to professional groups. The film recommends use of protective shields, primarily for boys and men of reproductive age and discusses safe practices for pregnant women. The 15-minute 16mm film may be ordered from American College of Radiology, Room 2920, 20 N. Wacker Dr., Chicago, IL 60606.

The AMA Board of Trustees has given its support to the need for "an organized cry of protest from the medical profession" on television violence. The action was based on "Effect of Television Violence on Children and Youth" in the Dec. 8 JAMA which says studies show that "violence viewing produces increased aggressive behavior in the young" and that changes in TV programming are warranted. The AMA will make the article and the Board's endorsement available to physicians and inform agencies and individuals in the TV industry of its position.

LIBRIUM®
(chlordiazepoxide HCl)

FOR ALL THE RIGHT REASONS.

- prompt and specific action
- documented benefit-to-risk ratio
- three dosage strengths to meet most therapeutic needs



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)
Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

LIBRIUM®
chlordiazepoxide HCl/Roche
5mg, 10mg, 25mg capsules

Please see following page.

LIBRIUM®
(chlordiazepoxide HCl)

FOR ALL THE RIGHT REASONS.

Yesterday's decision to use Librium for a clinically anxious patient was based on several good reasons. Safety. Effectiveness. Versatility. And the reasons you chose it yesterday are as valid today.

Librium has accumulated an unsurpassed clinical record. A record validated in several thousand papers published both here and abroad.

Librium, when used in proper dosage, rarely interferes with a patient's mental acuity or ability to perform. However, as with all CNS-acting agents, good medical practice suggests that patients be cautioned against hazardous activities requiring complete mental alertness.

Librium has an established safety record and a documented benefit-to-risk ratio. And Librium is used concomitantly with such drugs as cardiac glycosides, diuretics, anticholinergics and antacids.

So when you consider antianxiety therapy, consider Librium. It's a good choice. For today. And tomorrow.



ROCHE

PROVEN ADJUNCT FOR CLINICAL ANXIETY

LIBRIUM® C IV

chlordiazepoxide HCl/Roche

Please see preceding page for summary of product information.

EAST 10TH ST
NEW YORK N.Y.
10029

JOURNAL OF THE Mississippi STATE MEDICAL ASSOCIATION

AMERICAN REVOLUTION BICENTENNIAL 1776-1976

APRIL 1976

BALCONY

BECOTIN®
Vitamin B Complex

BECOTIN® with VITAMIN C
Vitamin B Complex with Vitamin C

BECOTIN®-T
Vitamin B Complex with Vitamin C, Therapeutic

MI-CEBRIN®
Vitamins-Minerals

MI-CEBRIN T®
Vitamin-Minerals Therapeutic

AND A WIDE VARIETY OF OTHER PHARMACEUTICALS

DISTA

DISTA PRODUCTS COMPANY
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

400944

This Month . . . Organophosphate Poisoning, 108th Annual Session Program, House of Delegates Handbook

M.S.M.A.

Both often



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

State Doctors Named Diplomates of ABFP

Twenty-one Mississippi physicians have been named diplomates of the American Board of Family Practice (ABFP) as a result of passing a certification examination offered by the ABFP. They are now certified in the specialty of family practice.

The intensive 2-day written examination taken by the doctors is designed to prove their ability in the areas of internal medicine, surgery, obstetrics, gynecology, pediatrics, psychiatry and community medicine.

To qualify for the examination a physician must have completed either a 3-year family practice residency or have been in family practice a minimum of six years and successfully completed 300 hours of continuing medical education approved by the American Academy of Family Physicians.

ABFP diplomates also must continue to show proof of competency in the field of comprehensive, continuing care of the family by being recertified every six years. No other medical specialty requires diplomates to prove competence on a continuing basis.

The latest group of diplomates brings the total number to more than 8,700. Most are members of the Academy of Family Physicians, the national association of family doctors. In addition to being the only national M.D. group to require members to take continuing medical study, the academy was chiefly responsible for securing specialty status for family practice.

The Mississippi doctors named diplomates are: Richmond Alexander, Jr., Laurel, Edgar E. Bobo, Pearl, William A. Brown, Jr., Mathiston, Robert Therrel Cates, Jackson, David Lee Clippinger, Gulfport, Elmo Pierce Gabbert, Meadville, Wilfred R. Gillis, Jackson, Charles D. Guess, Jackson, Charles A. Hollingshead, Laurel, Thomas R. Howell, Laurel, Jerald Stacy Hughes, Bay Springs, Robert N. Hurt, Indianola, Adron Keith Lay, Bay Springs, F. Lamar McMillin, Jr., Vicksburg, William Edwin Moak, Richton, James Sweptson Poole, Gloster, Guy H. Robinson, Indianola, Horton G. Taylor, Jr., Ripley, James E. Warrington, Shelby, Paul W. Warrington, Cleveland, and Jerry W. Welch, Laurel.

Is there a tablet containing *only* an expectorant and *only* Glyceryl Guaiacolate? YES!

1. Patient acceptable tablet dose.
2. Single entity expectorant.
3. Measured tablet dose.
4. Sugar-free tablet.

An identifiable white, scored tablet which significantly stimulates the secretion of respiratory tract fluid.

HYTUSS TABS

(GLYCERYL GUAIACOLATE 100mg.)





Composition: Each sugar-free compressed tablet contains glyceryl guaiacolate 100mg. **Action and Use:** This preparation utilizes the effective expectorant action of glyceryl guaiacolate which significantly stimulates the secretion of respiratory tract fluid. The increased flow of less viscid fluid favors expectoration and has a demulcent effect on the tracheobronchial mucosa. The primary usefulness of Hytuss Tabs is to promote the change from a dry, unproductive cough to a productive cough. Hytuss is therefore useful in treating coughs due to the common cold, bronchitis, laryngitis, tracheitis, pharyngitis, influenza and the measles. The expectorant action of Hytuss may also provide symptomatic relief in some chronic respiratory disorders when the patient experiences spasms of dry nonproductive coughing. **Precautions:** Extremely large amounts may cause nausea and vomiting. **Administration and Dosage:** *Adults*—1 tablet four times daily. *Children*—6 to 12 years of age; ½ tablet 3 or 4 times daily. HOW SUPPLIED: White, scored, sugar-free, tablet in bottles of 100 - 1,000 - 5,000. **Product Identification Mark:** Hy. **Literature Available:** On request.

Available through all drug wholesalers.

Hyrex

HYREX COMPANY

832 South Cooper
Memphis, Tenn. 38104

Volume XVII
Number 4
April 1976



JOURNAL of the Mississippi
STATE MEDICAL ASSOCIATION

• EDITOR
W. Moncure Dabney, M.D.
• ASSOCIATE EDITORS
George H. Martin, M.D.
Myron W. Lockey, M.D.
• MANAGING EDITOR
Nola Gibson
• PUBLICATIONS COMMITTEE
Lawrence W. Long, M.D.
Chairman
Frank L. Butler, Jr., M.D.
T. A. Baines, M.D.
and the editors
• THE ASSOCIATION
Jack A. Atkinson, M.D.
President
Lyne S. Gamble, M.D.
President-Elect
James P. Spell, M.D.
Secretary-Treasurer
C. D. Taylor, Jr., M.D.
Speaker
R. Faser Triplett, M.D.
Vice Speaker
Charles L. Mathews
Executive Secretary
H. Cody Harrell
Assistant Executive Secretary
William F. Roberts
Legal Counsel

The Journal of the Mississippi State Medical Association is owned and published monthly by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, $15.00 per annum; $2 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

CONTENTS

ORIGINAL PAPER

Organophosphate Insecticide Poisoning **91** Bruce Atkinson, M.D., Amory, MS

ANNUAL SESSION

Complete Program **95** Four Days in May

Handbook of the House of Delegates **109** Advance Reports

Proceedings of Special Session **116** October 23, 1975

EDITORIAL

Xeromammography **121** George H. Martin, M.D., Vicksburg, MS

THIS MONTH

The President Speaking **120** "Influencing Legislation"

Copyright 1976, Mississippi State Medical Association



Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

consider the effect on coexisting glaucoma when you prescribe a vasodilator*



a vasodilator that has not been reported to raise intraocular pressure

VASODILAN®
(ISOXSUPRINE HCl)

TABLETS, 20 mg.

the compatible vasodilator

Mead Johnson LABORATORIES

© 1976 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL-54118

*__Indications__: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

NEWSLETTER

April 1976

Dear Doctor:

Some 90 Mississippians have enrolled in the UMC study on aspirin and myocardial infarcts, but more volunteers are needed. Dr. Richard Hutchinson, assistant professor of medicine and program coordinator, says study participants must have had at least one heart attack within the last five years and have the consent of their personal physician. Study is to see if aspirin could help prevent recurring heart attacks because of its effect on the action of blood platelets.

> UMC is one of 30 U.S. institutions participating in the five year National Heart and Lung Institute study. Physicians who have patients interested in the study should write Aspirin Study, UMC, 2500 N. State St., Jackson, MS 39216 or phone 362-4411, ext. 2227 or 2280.

California Medical Association delegates, in San Francisco for the annual convention, voted 190 to 132 to continue their policy which calls for unified membership in the county and state medical societies and the AMA. In a related action, they approved an amended resolution for formation of an ad hoc committee to study and carry out reforms needed to preserve unity in the profession.

A state agency with the authority to require review and approval of health institution expenditures can, with the cooperation of hospitals, achieve substantial savings for both hospitals and patients, reports Health Insurance Association of America. HIAA studied the Connecticut agency which it said saved private sector patients "in excess of $30 million" in three years.

For the fourth consecutive academic period of the School of Medicine, medical alumni and friends of UMC have made possible the allocation of another $10,000 to be used for financial aid to needy Mississippi medical students. With this distribution by the Billy S. Guyton, M.D., Memorial Medical Education Loan Fund Board of Trustees, the total gifts now stand at $40,000 or 80 loans of $500.

Britain's Labor Government announced big cuts in public spending plans, conceding that the social welfare program is crippling the country's economy. Spending projections for health care will be among those reduced. Only substantial increase among 16 sectors receiving aid will go to private industry. A Briton making $125 a week now pays one-fourth of it to the government.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

POSTGRADUATE CALENDAR

April 13, 1976

MISSISSIPPI THORACIC SOCIETY MEETING
University Medical Center, Jackson

Sponsored by the Mississippi Thoracic Society, Mississippi Lung Association, the University of Mississippi School of Medicine, and the University Medical Center Division of Continuing Health Professional Education

Coordinator:
Walter Treadwell, M.D., associate professor of family medicine, the University of Mississippi School of Medicine

Participants will receive AAFP credit and AMA Category I, Physician's Recognition Award credit. Fee is $15, and advance registration is requested.

April 19-23, 1976

NEPHROLOGY INTENSIVE COURSE
University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education with partial support from Mississippi Regional Medical Program

Coordinator:
John D. Bower, M.D., associate professor of medicine and director of the artificial kidney unit, the University of Mississippi School of Medicine

This clinically oriented course will emphasize the reversible and treatable forms of kidney disease.

April 30, 1976

ANNUAL KIDNEY DISEASE SEMINAR
University Medical Center, Jackson

Sponsored by the Kidney Foundation of Mississippi, the University of Mississippi School of Medicine Departments of Medicine, Surgery (urology), and Pediatrics, and the University Medical Center artificial kidney unit and Division of Continuing Health Professional Education

Coordinator:
W. Lamar Weems, M.D., professor of surgery (urology) and chief of the division of urology, the University of Mississippi School of Medicine

Participants will focus on urinary tract infections.

for the inflamed phase of hemorrhoidal flare-up

Anusol-HC® Cream: Rx only. Each gram contains: Hydrocortisone Acetate 5.0 mg; Bismuth Subgallate 22.5 mg; Bismuth Resorcin Compound 17.5 mg; Benzyl Benzoate 12.5 mg; Peruvian Balsam 17.5 mg; Zinc Oxide 110.0 mg. Also contains the following inactive ingredients: propylene glycol, bismuth subiodide, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil and glyceryl monostearate. Non-staining.

Anusol-HC® Suppositories: Rx only. Each contains: Hydrocortisone Acetate 10.0 mg; Bismuth Subgallate 2.25%; Bismuth Resorcin Compound 1.75%; Benzyl Benzoate 1.2%; Peruvian Balsam 1.8%; Zinc Oxide 11.0%. Also contains the following inactive ingredients: bismuth subiodide, calcium phosphate, and coloring in a bland, hydrogenated oil-cocoa butter base.

CAUTION: Federal law prohibits dispensing Anusol-HC® Cream and Anusol-HC® Suppositories without prescription.

for the maintenance and protection phase

Anusol Suppositories and Ointment: Except for hydrocortisone acetate, these forms contain the same percentages of active ingredients as listed above.

Contraindications: History of sensitivity to any component. Topical corticosteroids should not be employed in tuberculous, fungal and most viral lesions of skin (including herpes, vaccinia and varicella).

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy they should not be used unnecessarily on extended areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment. When there is bacterial skin infection, topical corticosteroids should be used only with appropriate concomitant anti-microbial therapy. Prolonged or excessive use of corticosteroids might produce systemic effects.

Dosage and Administration: Anusol-HC Cream: *Adults*—Remove tube cap and attach the plastic applicator. After gentle bathing and drying of the area, apply to the exterior surface and gently rub in. For internal use, insert the applicator by applying gentle, continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories or Ointment.

Anusol-HC Suppositories: One suppository in the morning and one at bedtime, for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol.

Anusol Suppositories: One in the morning, one at bedtime; and one immediately following each evacuation.

Anusol Ointment: Apply freely to the anoderm as often as necessary, usually 2 to 4 times a day.
Full information available on request.

Warner Chilcott
Division,
Warner-Lambert Company,
Morris Plains,
New Jersey 07950

THE PROFESSIONAL SOURCE OF

COMFORT

FOR INTERNAL & EXTERNAL ANORECTAL CONDITIONS



Anusol-HC®

suppositories and cream
with hydrocortisone acetate. Rx only

pain and burning respond in minutes

- without belladonna alkaloids
- without CNS stimulants

Artist's interpretation in bas-relief of external hemorrhoids, postoperative anorectal wounds and anal dermatitis.

Famous Fighters



NEOSPORIN® Ointment
(polymyxin B-bacitracin-neomycin)
is a famous fighter, too.

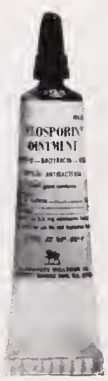
Provides overlapping, broad-spectrum antibacterial action to help combat infection caused by common susceptible pathogens (including staph and strep).

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

History of Medicine Society Meets

The next meeting of the UMC History of Medicine Society is set for Thursday, April 29, at 7:00 p.m. in the conference room of the Ole Miss Medical Alumni House on the University Medical Center campus.

Guest speaker is Gordon Rovelstad, D.D.S., professor of dentistry at UMC, who will discuss "Bicentennial Dentistry."

Reservations are $5.00 for members and $7.50 for nonmembers and should be sent to Dr. Ojus Malphurs, Communicative Disorders Lab, UMC, 2500 North State Street, Jackson, MS 39216. Yearly dues are $10.00.

National Rural Health Week Designated

The week of April 4-10, 1976, has been designated as "National Rural Health Week" and the American Medical Association and other concerned national organizations have urged their state and local constituencies to participate in community action to improve rural health.

The MSMA Council on Medical Service and Woman's Auxiliary to MSMA will seek recognition of and participation in "National Rural Health Week" by local medical societies, communities and hospitals.

Materials will be sent to each component society's officers and to officers of the auxiliary. The package of promotional ideas and material will also be available from MSMA headquarters.

Hill Crest
HOSPITAL
Hill Crest Foundation, Inc.

A non-governmental psychiatric hospital. Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved.
Phone: 205-836-7201



A short-term, intensive treatment center for psychiatric disorders, alcoholism, and drug abuse.

MEDICAL DIRECTOR:
James K. Ward, M.D.

Member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Birmingham Regional Hospital Council.

6869 Fifth Avenue South
Birmingham, Alabama 35212

TO COMPLETE YOUR HEALTH INSURANCE PICTURE, MSMA OFFERS ITS NEW COMPLETE HEALTH INSURANCE PACKAGE:

NEW MAJOR MEDICAL PLAN
Covers 80% of your eligible expenses after you satisfy your deductible amount. Choice of deductibles available. Pays expenses in and out of the hospital!

NEW HOSPITAL MONEY PLAN®
Pays a daily benefit for each day you spend in the hospital because of an accident or illness. Acceptance is GUARANTEED! Pays the benefits directly to *you*!

NEW EXCESS MAJOR MEDICAL PLAN
Picks up where basic insurance programs leave off. Pays 100% of eligible expenses in or out of the hospital—up to $250,000 maximum. And, premiums are LOW! Acceptance is GUARANTEED!

A complete health insurance picture is probably one of the most important items you can provide for your family's financial well-being. To help you combat the rising cost of hospital and medical care, MSMA has entirely revamped its health insurance program to give you the most complete and comprehensive program available . . . and at a low price all can appreciate. Find out more. Mail the coupon below for more information:

THE MSMA INSURANCE PROGRAMS ARE UNDERWRITTEN BY:



CONTINENTAL CASUALTY Co.
ASSOCIATION GROUP DIVISION
Chicago, IL 60685

a division of CNA/insurance

Please send me more details on the NEW MSMA insurance programs:

☐ **MSMA MAJOR MEDICAL PLAN** ☐ **MSMA HOSPITAL MONEY PLAN** ☐ **MSMA EXCESS MAJOR MEDICAL PLAN**

NAME_____

ADDRESS_____

CITY_____

STATE_____ ZIP CODE_____

MAIL TO: Thomas Yates & Co., MSMA Insurance Administrators
P.O. Box 1054, Jackson, Mississippi 39205

DATELINE

Humanities Seminars for MDs Are Set

Washington, D.C. - The National Endowment for the Humanities has announced four humanities seminars for medical practitioners this summer in Columbus, Ohio; Philadelphia, Pa.; Stanford University; and Galveston, Tx. The seminars will bring distinguished humanists from the fields of philosophy, religion, sociology and history together with physicians for a month of fulltime study. Seminars are free and attendants receive a stipend of $1,200.

Many Physicians Retire Early

Chicago, IL - A trend among the nation's physicians to retire at a much earlier age could adversely affect the delivery of health care in this country, the executive director of the American Retired Physicians Association has warned. Paperwork, red tape, government regulations and the constant threat of malpractice litigation are the major contributing factors to the decision to retire early, said Ralph Creer. Trend will mean fewer MDs in the 55-70 age group.

State Cancer Society Wins Award

Greenville, MS - Mississippi has won its first Honors Citation from the American Cancer Society. The award went to the Washington County Unit for a cancer-screening clinic for women inmates at Parchman State Prison. The project was a cooperative effort by the Mississippi division of ACS and the State Board of Health. A total of 89 persons received 247 examinations during the 2½ hour clinic and one woman was found to have cancer and another a precancerous condition.

Breast Feeding Is Encouraged

Evanston, IL - Physicians should encourage breast feeding among mothers, the American Academy of Pediatrics Committee on Nutrition has recommended in the February issue of Pediatrics. The committee said "breast milk has not been improved on as a reference standard" for infant nutrition, and the physical contact of breast feeding promotes better interaction between mother and infants -- if the contact is desired by the mother. AAP called for educational programs on breast feeding.

Pill May Cause Liver Tumors

Chicago, IL - Oral contraceptives may be the cause of tumors of the liver, says a Kentucky research group in the Feb. 16 JAMA. They report on 13 young women who developed liver tumors after taking "The Pill." Nine of the tumors were benign; four were malignant. Six tumors ruptured spontaneously and caused life-threatening hemorrhage. The increase of such tumors in women of childbearing age warrants the suspicion that contraceptive steroid hormones may be the cause, report states.

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Clinical Convention, Nov. 29-Dec. 4, Honolulu. Annual Convention, June 26-July 1, Dallas. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

La.-Miss. O. and O. Society, May 27-30, 1976, Point Clear, Ala. Arthur Hays, M.D., Secy., 3017 13th St., Gulfport 39501.

STATE AND LOCAL

Mississippi Academy of Family Physicians, Annual Meeting, July 7-10, 1976, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 108th Annual Session, May 3-6, 1976, Jackson. Charles L. Mathews, Executive Secy., 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Smith, Yazoo.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Gerald A. Smith, Secy., P.O. Box 128, Sumner 38957. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. A. K. Martinolich, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Reginald P. White, Secy., East Mississippi State Hospital, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, April, June, August, October, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., Jefferson Davis Memorial Hospital, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. D. Stanley Hartness, Jr., Secy., 314 Adams St., Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Lee H. Rogers, Secy., 610 Brunson Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, October. Cherie Friedman, Secy., 1004 Jackson Ave., Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

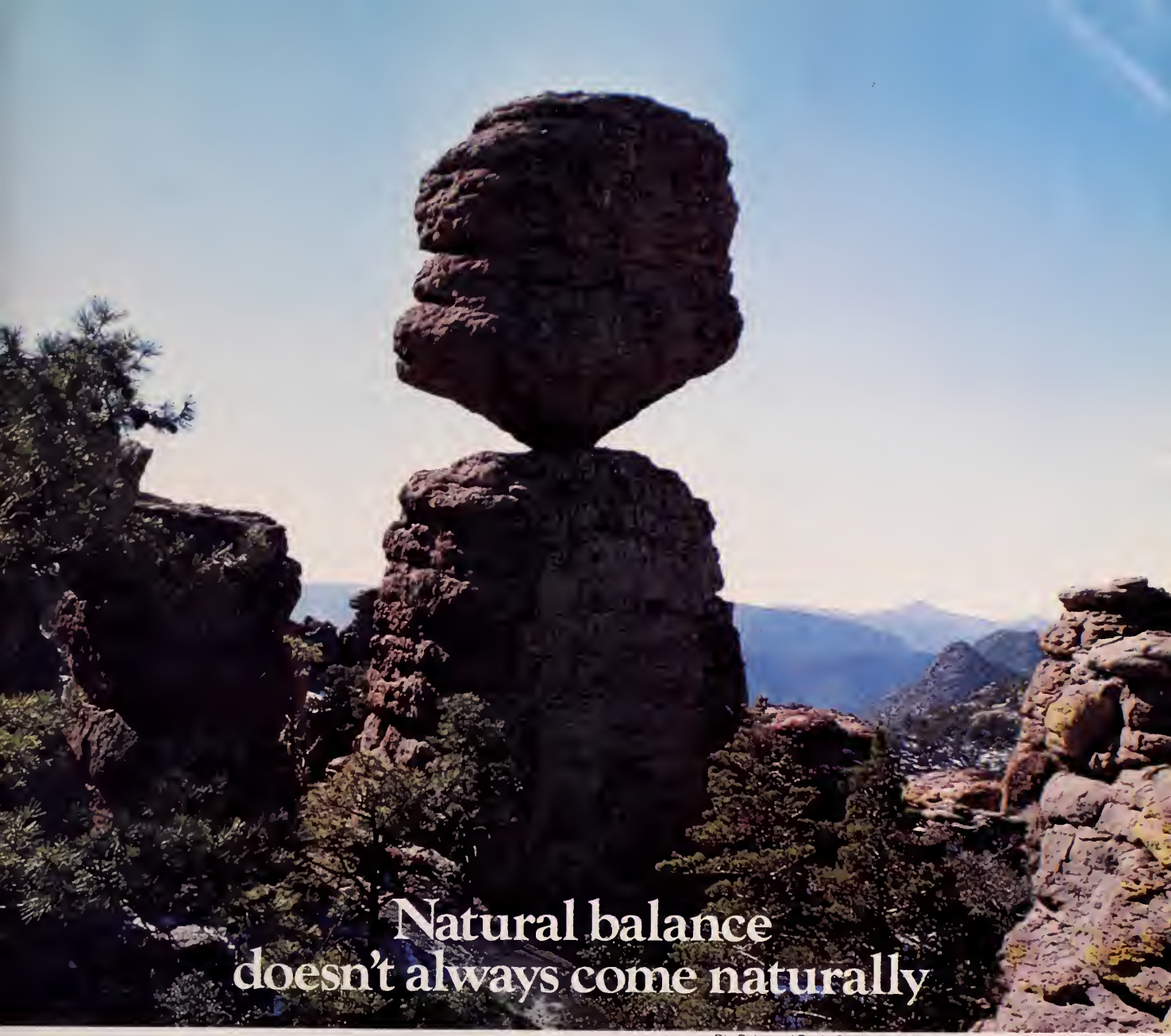
Prairie Medical Society, 2nd Tuesday, March, June, September, December. James H. Sams, Secy., P.O. Box 1381, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, May, July, September, November. Dewey Laner, Secy., Doctors Plaza, Suite 206, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. John L. Smith, Secy., No. 1 Medical Blvd., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.



Big Balanced Rock, Chiricahua Mountains, Arizona (approx 1,000 tons)

□ Found useful in the management of vertigo* associated with diseases affecting the vestibular system.
□ Can relieve nausea and vomiting often associated with vertigo.*
□ Usual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.
□ Also available as Antivert (meclizine HCl) 12.5 mg. scored tablets, for dosage convenience and flexibility.
□ Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for nausea, vomiting and dizziness associated with motion sickness.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

Effectiveness across the spectrum of most common forms of insomnia

Awake too long, awake too often, awake too early...

These are the most common forms of insomnia, and may occur singly or in any combination. The night of troubled sleep depicted here comprises all three types. As the night progresses from left to right, each sleep stage is identifiable by its own shade of gray. Blue represents "Awake."

As you can see, this hypothetical "patient" takes well over an hour to fall asleep, awakens several times during the middle of the night and awakens too early in the morning.

Sleep Stages

- Awake
- REM
- Stage 1
- Stage 2
- Stage 3
- Stage 4



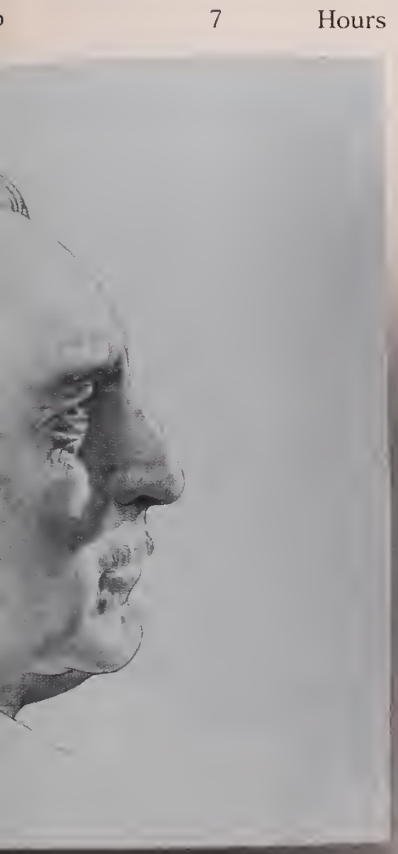
The insomnias most often occurring in young and older adults

For patients with trouble falling asleep (common in young adult insomnia patients), Dalmane (flurazepam HCl) 30 mg provides sleep within 17 minutes, on average. For those with trouble staying asleep or sleeping long enough (common in those over 50), Dalmane offers increased total sleep time with fewer nocturnal awakenings. These clinical results were demonstrated in studies conducted in four geographically separated sleep research laboratories[1-4]

The relative safety of Dalmane (flurazepam HCl) is well documented

Dalmane (flurazepam HCl) is relatively safe and well tolerated; morning "hang-over" has been infrequent. The usual adult dosage is 30 mg; in elderly or debilitated patients, limit initial dosage to 15 mg to preclude over-sedation, dizziness or ataxia. Caution patients about possible combined effects with alcohol and other CNS depressants.

Broad-spectrum medication for the most common forms of insomnia



Awake too early



Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.

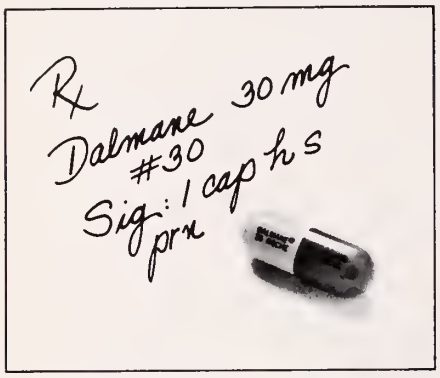
- □ induces sleep rapidly
- □ reduces nighttime awakenings
- □ lengthens total sleep time

ROCHE

Please see following page for a summary of complete product information.

Broad-spectrum medication for the most common forms of insomnia

Dalmane®
(flurazepam HCl) ℞



Objectively proved in the sleep research laboratory, Dalmane

- ☐ induces sleep within 17 minutes, on average
- ☐ reduces nighttime awakenings
- ☐ provides 7 to 8 hours sleep, on average, without repeating dosage

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES:

1. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
2. Frost JD Jr: A system for automatically analyzing sleep. Scientific exhibit at the 24th Clinical Convention of the American Medical Association, Boston, Nov 29-Dec 2, 1970; and at the 42nd annual scientific meeting of the Aerospace Medical Association, Houston, Apr 26-29, 1971
3. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
4. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ



ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Alabama Internists Meet May 21-22

Specialists in internal medicine and related medical fields will hold a two-day scientific meeting on May 21-22, 1976, at the Grand Hotel in Point Clear, Ala.

The Alabama Regional Meeting of the American College of Physicians (ACP) is designed to bring physicians up-to-date on late developments in the field of internal medicine.

Physicians who attend the regional meeting are eligible for credit toward the American Medical Association Physicians' Recognition Award in Category 1.

In charge of arrangements for the Alabama Regional Meeting is Dr. Thomas N. James, Birmingham, who serves as the ACP's representative in the state of Alabama.

WAYNE MEDICAL LABORATORY, INC.

Providing complete and/or reference laboratory service to hospitals, clinics and physicians.

General and specialized tests are offered. Profiles, Thyroid Studies, Pap Smears, Electrophoresis and other Laboratory procedures.

SINCE 1965

Send for fee schedule:

Wayne Medical Lab., Inc.
212 West Seventh St.
Laurel, MS 39440

601-426-2221 TWX—510-960-1993

PRINTING — OFFICE SUPPLIES

EQUIPMENT — FURNITURE



Premier Printing Company

2485 West Capitol Jackson, Mississippi
Phone 352-4091

it's the real thing

Enjoy Coca-Cola Trade-mark ®

70-37

Mississippi Council of Coca-Cola Bottlers

Miscellaneous Mississippi Medical News

Governor Cliff Finch has indicated his choice of the Mississippi Health Systems Agency, Inc., as the Health Systems Agency for Mississippi under requirements of Public Law 93-641, The National Health Planning and Resources Development Act of 1974. The Secretary of HEW will make the final determination. MHSA's president is Mr. Fred St. Clair, Executive Director of the Mississippi Optometric Association. MSMA will present a panel discussion about the National Health Planning and Resources Development Act during the upcoming 108th Annual Session on Monday afternoon, May 3.

All MSMA members are urged to be aware of amendments to the MSMA Constitution and By-Laws discussed on page 127 of this issue of the JOURNAL MSMA in the report of the Council on Constitution and By-Laws. The amendments, if adopted, will change the composition of the Council on Medical Education and realign the association's districts. Both amendments will be before the MSMA House of Delegates at its opening session on Monday, May 3, and members are urged to let their delegates know their views.

Six out of nine of MSMA's professional liability legislative proposals were alive and well as the Mississippi Legislature passed important deadlines in March for reporting and passing bills in the originating house. MSMA proposals dealing with informed consent, the "collateral source" rule and restriction or suspension of a physician's license for incompetency failed to make the deadlines. There is a good chance the latter will be revived by amendment to a bill that is still alive.

The Mississippi Foundation for Medical Care has scheduled a series of medical audit workshops through June 1976 for physicians and medical audit assistants. The day-and-a-half meetings have been approved for 9 hours credit toward the AMA Physicians' Recognition Award and American Academy of Family Physicians certification. Videotapes on medical audits are also available on loan from the MFMC.

MSMA's new Committee on High Risk Maternal and Newborn Care is conducting a survey of Mississippi hospitals to determine resources for such care in Mississippi. A survey form signed by committee chairman, Dr. Wendell Stockton of Amory, went to all hospitals in the state during March.

helping you change things for the better

Canton Exchange Bank

A FULL SERVICE BANK

"Your Account Handled in Strict Confidence"

Each depositor insured to $40,000

Branch Offices

Canton East Branch
Bank Of Madison
Bank Of Ridgeland

FDIC

Federal Deposit Insurance Corporation

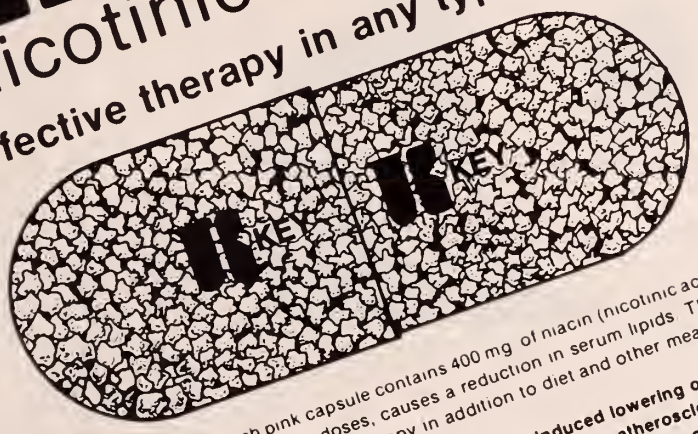
"Our 95th Year Of Continuous Service"

The Original
Slow Release
Form of Nicotinic Acid

nico-Span®

(nicotinic acid) 400 mg. capsules

Effective therapy in any type of drug responsive hyperlipidemia.



DESCRIPTION: Each pink capsule contains 400 mg. of niacin (nicotinic acid) in a special pelletized formulation for prolonged release

ACTIONS: Niacin, in large doses, causes a reduction in serum lipids. The exact mechanism of action is unknown.

INDICATIONS: As adjunctive therapy in addition to diet and other measures in the treatment of hypercholesterolemia and hyperbetalipoproteinemia.

Notice: It has not been established whether drug-induced lowering of serum cholesterol or other lipid levels has a detrimental, a beneficial or no effect on the morbidity due to atherosclerosis or coronary heart disease. Several years will be required before current investigations can yield an answer to this question.

CONTRAINDICATIONS: Niacin is contraindicated in patients with hepatic dysfunction or in patients with active acute peptic ulcer.

WARNINGS: The use during pregnancy and lactation or in women of childbearing age requires careful weighing of potential benefits versus possible hazards to the mother and child. There are insufficient studies done for usage in children.

PRECAUTIONS: Patients with diabetes, gall bladder disease, past history of jaundice, liver disease, or peptic ulcer should be observed closely. At initial stage of therapy, liver function and blood glucose should be monitored at frequent intervals. Adjustment of diet and/or hypoglycemic therapy may be necessary. Patients undergoing antihypertensive therapy may experience an added vasodilating effect with resulting postural hypotension. Use with caution in patients predisposed to gout.

ADVERSE REACTIONS: Severe flushing, decreased glucose tolerance, activation of peptic ulcer, abnormal liver function tests, jaundice, gastrointestinal disorders, dry skin, pruritus, hyperuricemia, toxic amblyopia, hypotension, transient headache.

DOSAGE AND ADMINISTRATION: The dose and frequency for the administration of NICO-SPAN should be adjusted to the response of the patient. Slow build-up of dosage in gradual increments is recommended to observe efficacy and/or adverse effects. One or two capsules three times a day is the usual dosage. The maximum daily dosage is 6 grams.

Please arrange to provide starter samples and/or complimentary "Starter" prescription booklets for:
nico-Span® (nicotinic acid, 400 mg.)

Samples ☐ "Starter" Rx's ☐

Dr. _____ Specialty _____

Street _____

City _____ State _____ Zip _____

Mail to: Key Pharmaceuticals, Inc. 50 N.W. 176th Street, Miami, Florida 33169

KEY PHARMACEUTICALS, INC.
Miami, Florida 33169 (U.S.A.)

Warren Edwards: THE ASSISTANT'S ASSISTANT.



Warren Edwards, Manager, Medical Assistant Liaison, and Mrs. Carol Smith, President, AAMA, Mississippi Society, Central Chapter, refer to the Blue Cross and Blue Shield Procedure Manual.

When medical assistants need assistance, they know they can count on Warren Edwards. He works closely with medical assistants throughout Mississippi . . . from Southaven to Biloxi, from Vicksburg to Meridian . . . and all points in between.

Along with other Blue Cross and Blue Shield representatives, Warren Edwards strives to provide a good working relationship with physicians, medical assistants, and other health care professionals.

Get to know him, and you'll get to know that "helping people is his full-time job."

Blue Cross®
Blue Shield®
of Mississippi

P.O. Box 1043 / 530 E. Woodrow Wilson Ave.
Jackson, Mississippi 39205 / Tel. 982-0010

® Registered Marks Blue Cross Association
® Registered Service Marks of the National Association of Blue Shield Plans

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
April 1976, Vol. XVII, No. 4

ORIGINAL PAPERS

Organophosphate Insecticide Poisoning

BRUCE ATKINSON, M.D.
Amory, Mississippi

POISONING due to organophosphate insecticides is one of the few clinical situations in which the immediate administration of specific antidotes may be lifesaving. Twelve cases seen at University Hospital are reported here, and details of the diagnosis and management of this condition are reviewed.

The 12 cases are summarized in Table I. Some additional comments are pertinent.

In case 1, the identity of the ingested substance was not determined. The presentation of muscular weakness, miosis, and hypotension, along with the immediate response to specific therapy, established a clinical diagnosis of organophosphate poisoning.

In case 2 the patient was rushed to his local physician immediately after he was seen ingesting the insecticide. Gastric lavage was performed, and atropine was given. On transfer to University Hospital he was asymptomatic and was observed without any further therapy.

The patient in case 3 played in a cotton field which had been sprayed a few hours earlier. He presented the next morning, unconscious, with classical signs of organophosphate poisoning. Atropine, 1.2 mg, and pralidoxime (PAM), 200 mg, were given. He became alert transiently, but the muscle weakness progressed, and he had a cardiorespiratory arrest from which he could not be resuscitated. Autopsy revealed severe pulmonary edema and hemorrhage with extensive bronchopneumonia.

Cases 5, 6, 7, and 8 are four brothers who played in a cotton field recently sprayed with EPN. The boys' mother suspected that they had eaten some dirt from the field. They became symptomatic on the day of exposure, with lethargy, weakness, salivation, and vomiting. They were still symptomatic when seen four days later at University Hospital, but all four responded well to atropine and PAM.

The author points out that organophosphate insecticide poisoning may be suggested by a history of exposure or by the characteristic symptoms and signs, especially muscle weakness, or fasciculations, miosis and excessive secretions. Treatment with atropine, PAM, decontamination and general support will usually effect a prompt recovery. He discusses 12 cases of organophosphate insecticide poisoning which were seen at the University Medical Center.

In case 9 the patient was accidentally doused with parathion in the face and chest. Infusion of PAM, 1000 mg, was begun, but after 300 mg had been given he developed a generalized urticarial rash. The PAM was discontinued, and the urticaria disappeared. Fortunately, this amount of PAM, along with more than 5 mg of atropine, resulted in clearing of all signs of poisoning.

The patient in case 12 ingested Diazinon in a suicide attempt. He was the only one of our cases whose exposure to organophosphates was not in an agricultural environment. He responded well to therapy.

DISCUSSION

Organophosphate compounds are widely used as insecticides in Mississippi. Table II offers a partial

From the Department of Medicine, University of Mississippi Medical Center, Jackson, MS.

listing of substances which may be implicated as poisons. The use of organophosphates has increased in recent years in preference to chlorinated hydrocarbon insecticides such as DDT. Organophosphates do not accumulate in human or animal tissues, and their long-term effect on ecology is not great. Their acute toxic effects, however, may be fatal.

Exposure to organophosphates in Mississippi is most common on the farm. Eleven of our twelve patients either worked with the compound or lived near fields where it was being used. Organophosphates are well absorbed from the skin and mucous membranes, as well as after ingestion. Empty pesticide containers may be handled or played in, resulting in contact exposure.[1] A new source of contact exposure has recently been described: dog and cat flea collars.[2] These collars contain organophosphate and have caused symptoms of low dose poisoning in both animals and humans.

Once absorbed, organophosphates bind firmly to the active sites of cholinesterase enzymes. There are two classes of these enzymes, pseudocholinesterase (found in liver and plasma) and true cholinesterase or acetyl cholinesterase (found in red blood cells and in the cholinergic synapses of the nervous system). Symptoms of organophosphate poisoning result from inactivation of the acetyl cholinesterase of the nervous system. These symptoms begin within 24 hours of exposure; they appear sooner with ingestion than with skin contact. Ingestion of large doses may produce typical symptoms within five minutes.

The characteristic symptoms and signs of organophosphate poisoning result from the accumulation of acetycholine in parasympathetic synapses, motor nerves, and the central nervous system. Common presenting symptoms and signs related to the site of action are shown in Table III. Three of the most common findings are muscle weakness or fasciculations, miosis, and excessive secretion from bronchial, lacrimal, salivary, and sweat glands. The presence of these signs without other obvious cause should suggest the diagnosis and the need for immediate treatment. Other commonly present findings are headache, nausea and vomiting, fever, altered sensorium, dyspnea, and abdominal pain.[3] The garlic-like odor of organophosphate is often detected on the breath, clothing, or skin.

TABLE I

CASES OF ORGANOPHOSPHATE POISONING ADMITTED TO UNIVERSITY HOSPITAL, 1965-1975

Case No.	*Year*	*Age/ Sex*	*Substance*	*Exposure*	*Clinical Manifestations* WEAKNESS	MIOSIS	SECRETIONS	OTHER	*Treatment*	*Outcome*
1	1965	2/F	Unknown	Ingestion	+	+	—	Hypo-tension	Atropine PAM 200 mg.	Recovered
2	1965	2/M	Dimethyl phosphate	Ingestion	—	—	—	—	Atropine	Recovered
3	1966	18 mo/ M	"Cotton poison"	Contact	+	+	+	Fever 103°	Atropine PAM 200 mg.	Died
4	1968	7 mo/ M	"Cotton poison"	Ingestion	+	+	+	Garlic odor	Atropine PAM 225 mg.	Recovered
5	1968	2/M	EPN	Contact &/or ingestion	+	—	+	Fever, Vomiting Abd. pain	Atropine PAM 200 mg.	Recovered
6	1968	3 mo/ M	EPN	Contact &/or ingestion	+	—	+	—	Atropine PAM 100 mg.	Recovered
7	1968	6/M	EPN	Contact &/or ingestion	+	—	—	—	Atropine PAM 600 mg.	Recovered
8	1968	3/M	EPN	Contact &/or ingestion	+	—	—	—	Atropine PAM 400 mg.	Recovered
9	1969	12/M	Parathion	Contact	+	+	+	Vomiting Abd. pain	Atropine PAM 300 mg.	Recovered
10	1970	31/M	Phosdrin	Contact	—	—	+	Vomiting Headache	Atropine	Recovered
11	1972	14/M	Parathion	Contact	+	—	+	Vomiting Headache	Atropine PAM 500 mg.	Recovered
12	1974	19/M	Diazinon	Ingestion	+	+	+	—	Atropine PAM 2 Gm.	Recovered

All patients received atropine in varying amounts, usually in multiple doses.

The usual cause of death is respiratory failure, from a combination of factors: depression of the respiratory center, weakness of respiratory muscles, bronchospasm, and increased bronchial secretions. A secondary pneumonia may develop and require treatment. The blood pressure is usually well maintained, but hypotension may develop after the first 24 hours.

TABLE II

TOXICITY OF SOME ORGANOPHOSPHATE INSECTICIDES

Most toxic
Parathion (E-605)
Thimet (phorate)
TEPP
Phosdrin (mevinphos)
Paraoxon (E-600)
Di-Syston
Bidrin
Methyl parathion
VC-13
EPN
Guthion
Azodrin
Toxic
Diazinon
Delnav
Dipterex
Coumaphos
Dichlorvos
Trithion
Less toxic
Malathion
Chlorthion
Rulene
Meta-Systox
Ronnel
Phostex

Routine laboratory studies are not helpful. Transient hyperglycemia and leukocytosis have been reported.[3] The urine may contain p-nitrophenol, a metabolite of many organophosphates. The most specific laboratory test is measurement of the cholinesterase activity of the blood. Erythrocyte cholinesterase activity reflects the inhibition of acetyl cholinesterase in the central nervous system, but the simpler plasma pseudocholinesterase has been found to accurately reflect the severity of the poisoning. Cholinesterase levels are valuable in confirming the diagnosis of organophosphate poisoning, but treatment should never be delayed to await test results.

TABLE III

SYMPTOMS AND SIGNS OF ORGANOPHOSPHATE POISONING

Skeletal muscle	Weakness, fasciculations, cramps
Central nervous system	Headache, confusion, slurred speech, ataxia, emotional lability and irritability, fever, convulsions, coma, depression of respiratory and circulatory centers
Exocrine glands	Increased sweating, salivation, lacrimation, and bronchial secretion
Gastrointestinal system	Nausea, vomiting, diarrhea, abdominal pain, loss of sphincter control
Cardiovascular system	Bradycardia, hypotension (late)
Pulmonary	Dyspnea, wheezing, cough, chest tightness, pulmonary edema
Eyes	Miosis, blurred vision

The levels may be useful in persons who are occupationally exposed to organophosphates. It has been suggested that a person with chronic exposure, as well as one who is recovering from an acute poisoning, should not return to work around organophosphates until his cholinesterase levels are at least 75 per cent of normal.[4]

Treatment of organophosphate poisoning requires two specific drugs, atropine and pralidoxime (PAM, 2-PAM, Protopam). Atropine blocks the action of the accumulated acetylcholine. Atropinization will reverse the parasympathetic effects, but not the muscle fasciculations and weakness. It is given intramuscular or intravenous, in doses of one to five mg, depending on the severity of symptoms. Doses may be repeated at frequent intervals; various sources recommend as little as three minutes[5] or as much as thirty.[3] The desired end point of atropinization includes dry mouth, dry and flushed skin, and mydriasis; however, the pupil will not dilate even with adequate atropinization if the conjunctiva has been directly exposed to organophosphate.

PAM breaks the fixed bond between the organophosphate and cholinesterase and allows the poison to be metabolized and excreted. It will reverse all symptoms, including muscle weakness. It is given intravenously, in a dose of one gm for adults and 20 to 50 mg per kilogram body weight for children. If no improvement occurs, this dose may be repeated in an hour and a slow infusion may be begun. PAM can produce clinical improvement even when given as long as five days after poisoning.[3]

Prevention of further absorption of organophosphate is essential. This involves removing and laundering all clothing; thoroughly scrubbing the skin and hair; and emptying the stomach contents by lavage when ingestion is likely. Attention should be given to gentle washing of the conjunctiva when facial exposure has occurred. Respiratory support with intubation, ventilation, and endotracheal suction may be necessary. Morphine and aminophylline are specifically contraindicated.

It has been suggested that improvements in packaging would prevent many cases of organophosphate poisoning.[1] Containers should bear as little resemblance to food or beverage containers as possible. Rinsing empty containers with water removes most of the residue. More attention to safety by the home gardener in the preparation and use of insecticide sprays is needed. In particular, spraying on a windy day should be avoided. The problem of children playing in sprayed fields is a serious one, which will recur if parents are not aware of the danger involved.

In summary, organophosphate insecticide poisoning may be suggested by a history of exposure or by the characteristic symptoms and signs, especially muscle weakness or fasciculations, miosis, and excessive secretions. Treatment with atropine, PAM, decontamination, and general support will usually effect a prompt recovery. ★★★

200 North Third Street (38821)

The author wishes to acknowledge appreciation to Dr. Arthur Hume for his encouragement and assistance.

REFERENCES

1. Gehlbach, S. H. et al: Pesticide Containers—their Contribution to Poisoning. Arch. Environ. Health 30:49-50, 1975.
2. Flea Collar Syndrome: Mississippi State Board of Health Weekly Morbidity Report, March 28, 1975.
3. Namba, T. et al: Poisoning Due to Organophosphate Insecticides. Am. J. Med. 50:475-492, 1971.
4. Milby, T. H.: Prevention and Management of Organophosphate Poisoning. J.A.M.A. 216:2131-2133, 1971.
5. Mayer, B. W. et al: Organophosphates—a Pediatrie Hazard. Am. Family Physician 11:121-124, 1975.

The chances of dying from emphysema and chronic bronchitis are six times greater among smokers than non-smokers, according to the American Lung Association. The Christmas Seal Association urges all smokers to "Kick the Habit." For helpful tips on stopping smoking, contact the Mississippi Lung Association, P. O. Box 9865, Jackson, MS 39206.

108th Annual Session

Mississippi State Medical Association
May 3-6, 1976
Jackson

THE MSMA CONVENTION moves back to Jackson this year for the first time since 1968 as the 108th Annual Session of the association gets underway May 3-6 at the new Holiday Inn Downtown. Nine scientific sections, fifteen specialty and related groups, three medical alumni occasions, technical and scientific exhibits, the House of Delegates, and a host of fellowship events are slated for the four-day meet.

Dr. Jack A. Atkinson of Brookhaven, association president, will address the opening meeting of the House of Delegates on May 3. House Speaker C. D. Taylor, Jr., of Pass Christian and Vice Speaker Faser Triplett of Jackson said that reports and resolutions will be presented at the opening meeting. Final action will come on May 6 when 1976-77 officers are also elected.

Dr. Lyne S. Gamble of Greenville will be inaugurated president for the new year during closing ceremonies on the final day.

Dr. James P. Spell of Jackson said that the Scientific Assembly will open on Sunday evening, May 2, and continue through Wednesday afternoon. The Scientific Assembly has been approved for 12 hours of MAFP prescribed credit. Special postgraduate education opportunities are a urology seminar on Sunday afternoon and a dermatological seminar on Monday morning. Dr. Spell heads the group which has planned and scheduled the general and specialty sessions, exhibits and fellowship occasions.

Principal speaker for the annual session is Dr. Max H. Parrott of Portland, Oregon, president of the American Medical Association. He is scheduled to address the opening meeting of the House of Delegates on May 3, Dr. Atkinson said.

The MSMA Auxiliary will conduct its 53rd Annual Session concurrently during May 2-5, also headquartering at the Holiday Inn Downtown, according to Mrs. Edward Hill of Hollandale, state president. Mrs. W. A. Brown of Mathiston will be inaugurated 1976-77 president of the auxiliary at the meeting. General chairwomen are Mrs. John Estess of Hollandale, convention; Mrs. Cecil Knox, Jr., of Vicksburg, registration; Mrs. Carl Nichols of Leland and Mrs. Frank Acree of Greenville, luncheon.

OFFICIAL CALL

To all members of the Mississippi
State Medical Association:

The 108th Annual Session of the Mississippi State Medical Association is called to meet at Jackson, Mississippi, on Monday, May 3, 1976, pursuant to Article V of the Constitution. The House of Delegates will be convened at 9 o'clock in the morning at the Holiday Inn Downtown on May 3.

The Scientific Assembly, consisting of the nine general sessions, will meet during May 2-5, 1976.

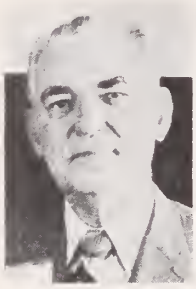
No member or guest will be permitted to participate in any aspect of the annual session until regularly registered.

JACK A. ATKINSON
PRESIDENT
JAMES P. SPELL
SECRETARY-TREASURER

Medical alumni occasions are set for Monday evening and events are scheduled by Ole Miss, Tulane and Tennessee. The annual association fellowship party has been expanded this year to a cocktail reception and banquet with entertainment by the Gaslight Road Show from Chicago. A bicentennial theme will share billing with the roaring twenties atmosphere of the road show for the party which will begin at 7:00 p.m. on Tuesday evening, May 4. Advance tickets may be ordered from MSMA.

Room reservations at the Holiday Inn Downtown are being made through the MSMA office in Jackson; contact Barbara Shelton for assistance in this regard.

STATE OFFICERS 1975-1976



DR. ATKINSON

PRESIDENT
JACK A. ATKINSON
Brookhaven



DR. GAMBLE

PRESIDENT-ELECT
LYNE S. GAMBLE
Greenville

SECRETARY-TREASURER
JAMES P. SPELL
Jackson

VICE PRESIDENTS
J. ED HILL, Hollandale
WILLIAM B. HOPSON, JR., Vicksburg
J. P. CULPEPPER, III, Hattiesburg

SPEAKER OF THE HOUSE OF DELEGATES
C. D. TAYLOR, JR., Pass Christian

VICE SPEAKER OF THE HOUSE OF DELEGATES
R. FASER TRIPLETT, Jackson

EDITOR
W. MONCURE DABNEY, Crystal Springs

ASSOCIATE EDITORS
GEORGE H. MARTIN, Vicksburg
MYRON W. LOCKEY, Jackson

DELEGATES TO AMA
G. SWINK HICKS, Natchez
JOSEPH B. ROGERS, Biloxi

BOARD OF TRUSTEES

JAMES O. GILMORE, Oxford, Chairman
ROBERT S. CALDWELL, Tupelo
GERALD P. GABLE, Hattiesburg
WHITMAN B. JOHNSON, JR., Clarksdale
SIDNEY O. GRAVES, JR., Natchez
ARTHUR A. DERRICK, Durant
CARL G. EVERS, Jackson
MAX L. PHARR, Jackson
JOE S. COVINGTON, Meridian
PAUL H. MOORE, Pascagoula

EXECUTIVE OFFICE

CHARLES L. MATHEWS, Executive Secretary
H. CODY HARRELL, Assistant Executive Secretary
WILLIAM F. ROBERTS, Executive Assistant and Legal Counsel
NOLA GIBSON, Managing Editor, JOURNAL MSMA
BARBARA SHELTON, Membership Director

LIVING PAST PRESIDENTS

LAMAR ARRINGTON, Meridian	1952-53
S. LAMAR BAILEY, Kosciusko	1955-56
HOWARD A. NELSON, Greenwood	1957-58
GUY T. VISE, Meridian	1958-59
STANLEY A. HILL, Corinth	1959-60
G. SWINK HICKS, Natchez	1960-61
LAWRENCE W. LONG, Jackson	1961-62
C. P. CRENSHAW, Collins	1962-63
OMAR SIMMONS, Newton	1964-65
EVERETT CRAWFORD, Tylertown	1965-66
JAMES T. THOMPSON, Moss Point	1966-67
TEMPLE AINSWORTH, Jackson	1967-68
JOSEPH B. ROGERS, Biloxi	1968-69
JAMES L. ROYALS, Jackson	1969-70
PAUL B. BRUMBY, Lexington	1970-71
CHARLES R. JENKINS, Laurel	1972-73
ARTHUR A. DERRICK, JR., Durant	1973-74
J. T. DAVIS, Corinth	1974-75

ACTIVITIES CALENDAR

REGISTRATION

General Registration for the Scientific Assembly and House of Delegates will be located at the second level (Mezzanine) in the Holiday Inn Downtown. No person may be admitted to any activity of the annual session without first registering. **There will be a registration fee of $25.00 for nonmember physicians except interns and residents.** Hours of registration will be 2:00 to 4:00 p.m., Sunday, May 2; 8:00 a.m. to 5:00 p.m., Monday, Tuesday and Wednesday, May 3, 4 and 5; and 8:00 to 9:00 a.m., Thursday, May 6.

SUNDAY, MAY 2, 1976

12:00 noon Mississippi Psychiatric Association Luncheon Meeting, Pecan I
1:00 p.m. Urology Seminar, Walnut Room
2:00 p.m. Auxiliary Hospitality Area and Registration, First Floor Lobby
2:00 p.m. MSMA Registration, Second Level Lobby

3:00 p.m. MSMA Section on Anesthesiology, Pecan II
3:00 p.m. Mississippi Association of Pathologists Business Meeting, Southern Pine I
5:00 p.m. Mississippi Society of Anesthesiologists Cocktail Party and Dinner, Pecan I

MONDAY, MAY 3, 1976

7:00 a.m. Reference Committee Breakfast, Hickory Room
9:00 a.m. House of Delegates, Delta Hall I
9:00 a.m. Mississippi Association of Pathologists Business Meeting and Scientific Session, Southern Pine I
9:00 a.m. Dermatological Seminar, Walnut Room
9:30 a.m. Auxiliary Finance Committee Meeting, Pecan I
10:30 a.m. Mississippi Orthopaedic Society Scientific Meeting and Luncheon, Willow I and II
12:00 noon Mississippi Urological Society Luncheon and Business Meeting, Hickory Room
12:00 noon Mississippi Association of Pathologists Luncheon, Southern Pine II
1:30 p.m. Mississippi Foundation for Medical Care Annual Meeting, Delta Hall I
2:30 p.m. Reference Committee on Reports of Officers, and Councils, Walnut Room
3:00 p.m. Auxiliary Preconvention Board Meeting, Pecan II
3:45 p.m. Council on Constitution and By-Laws, Southern Pine I
4:00 p.m. Ole Miss Medical Alumni Business Meeting, Hickory Room
6:00 p.m. Tulane Medical Alumni Reception, Pecan I
7:00 p.m. Tennessee Medical Alumni Reception, Walnut Room
7:00 p.m. Ole Miss Medical Alumni Cocktail Party and Banquet, Delta Halls I and II

TUESDAY, MAY 4, 1976

7:30 a.m. Academy of Facial Plastic and Reconstructive Surgery Breakfast and Scientific Program, Willow I
7:30 a.m. American College of Surgeons Officers Breakfast, Pecan II
7:30 a.m. Breakfast Meeting of MSMA Board, Officers and Component Society Presidents and Secretaries, Walnut Room
9:00 a.m. MSMA Section on EENT, Pecan I
9:00 a.m. MSMA Section on Surgery, Delta Hall I
9:30 a.m. Auxiliary General Session, Southern Pine I and II
12:00 noon Mississippi EENT Association Luncheon, Pecan II
12:00 noon Mississippi Society of Internal Medicine Luncheon, Willow I
12:00 noon American College of Surgeons Luncheon, Delta Hall II
12:30 noon Mississippi Neurosurgical Society Luncheon, Willow II
1:00 p.m. Auxiliary Luncheon, Country Club of Jackson
1:30 p.m. American College of Surgeons Scientific Meeting, Delta Hall I
1:30 p.m. MSMA Section on Radiology, Hickory Room
1:30 p.m. MSMA Section on Pediatrics, Walnut Room
1:30 p.m. MSMA Section on Medicine, Southern Pine I and II
3:30 p.m. Auxiliary Postconvention Board Meeting, Pecan I
7:00 p.m. MSMA Bicentennial Celebration Party, Delta Halls I and II

WEDNESDAY, MAY 5, 1976

7:30 a.m. MSMA Past Presidents' Breakfast, Hickory Room
9:00 a.m. MSMA Section on Family Practice, Walnut Room
9:00 a.m. Auxiliary Past Presidents' Breakfast, Pecan II
10:00 a.m. Auxiliary Workshop, Southern Pine II
11:00 a.m. Nominating Committee, Hickory Room
12:00 noon Mississippi Academy of Family Practice Luncheon, Delta Hall I
12:00 noon MSMA 50 Year Club Luncheon, Willow I
12:00 noon Mississippi Ob-Gyn Society Luncheon, Pecan II
1:30 p.m. MSMA Section on Ob-Gyn, Pecan I
1:30 p.m. MSMA Section on Preventive Medicine, Willow II
3:00 p.m. Tonometry Course for Non-Ophthalmologists, Walnut Room
3:30 p.m. MSMA Committee on High Risk Maternal and Newborn Care meeting, Hickory Room
6:30 p.m. Flying Physicians Association Dinner, Pecan I

THURSDAY, MAY 6, 1976

9:00 a.m. House of Delegates, Delta Hall I

EXECUTIVE BUSINESS



DR. TAYLOR

C. D. Taylor, Jr.
Pass Christian, Speaker



DR. TRIPLETT

R. Faser Triplett
Jackson, Vice Speaker

HOUSE OF DELEGATES

May 3, 1976, 9:00 a.m.
Holiday Inn Downtown



DR. PARROTT

MEETINGS OF THE HOUSE OF DELEGATES

The opening meeting of the House will be called to order by the President, and the Speakers will announce the order of business. An open meeting on May 3, to which all MSMA and Auxiliary members are invited, will feature addresses by Dr. Jack A. Atkinson, the president, and Dr. Max Parrott, president of the American Medical Association. The adjourned meeting of the House will convene at 9:00 a.m. on May 6.

REFERENCE COMMITTEES

Reports of Officers, Board of Trustees and Council, May 3, Walnut Room, 2:30 p.m.
Constitution and By-Laws, May 3, Southern Pine I, 3:45 p.m.
Nominating Committee, May 5, Hickory Room, 11:00 a.m.

THE SCIENTIFIC ASSEMBLY

COUNCIL ON SCIENTIFIC ASSEMBLY

JAMES P. SPELL, Chairman

THE COUNCIL

JAMES M. COOPER, Chairman, Anesthesiology

KATHERINE ALDRIDGE, Secretary



DR. SPELL

MILAM S. COTTEN, Chairman, EENT
JAMES W. RAYNER, Secretary
RALPH L. BROCK, Chairman, Family Practice
HARDY B. WOODBRIDGE, JR., Secretary
BERNARD BOOTH, Chairman, Medicine
JOE M. ROSS, JR., Secretary
I. E. GADDY, Chairman, Ob-Gyn
WADIE ABRAHAM, Secretary
JAMES A. SHEFFIELD, Chairman, Pediatrics
ROBERT L. ABNEY, III, Secretary
GEORGE J. TAYLOR, Chairman, Preventive Medicine
W. E. RIECKEN, JR., Secretary
MICHAEL E. JABALEY, Chairman, Surgery
HENRY B. TYLER, Secretary
JOHN Y. GIBSON, Chairman, Radiology
BERNARD BLUMENTHAL, Secretary

THE SCIENTIFIC EXHIBIT

Physicians, foundations, organizations, and major medical institutions will present the Scientific Exhibit. Physician-members of the Mississippi State Medical Association are eligible for the Aesculapius Award given for excellence of presentation, quality of content, and originality. Others may not participate in this competition, but they are eligible for the association's Scientific Achievement Award, a sculptured bronze medallion, in recognition of the best presentation by a nonmember. The Scientific Exhibit is located in the Raintree I and II rooms.

EXHIBITS AND AUTHORS

"Dyslexia and Learning Disabilities"
Mississippi EENT Association
"Prevent Blindness"
Mississippi Society for the Prevention of Blindness
"The Challenge of Rural Medicine"
Medical Staff, Field Memorial Hospital, Cen-

treville; and Tulane University School of Medicine, New Orleans

"Adolescent Care Unit" Brandon
United Ostomy Association, Jackson, MS Chapter

"Correction of Type C Complete Atrioventricular Canal: Surgical Considerations"
Noel L. Mills, John L. Ochsner, and Terry D. King, Ochsner Clinic, New Orleans

"Coronary Arteriosclerosis Surgical Treatment"
Charles W. Pearce, White E. Gibson, III, and Rudolph Weichert, III, New Orleans

"Spine Deformity—Don't Miss It (Scoliosis—What's That?)"
Hugh P. Brown, Department of Orthopaedic Surgery, University of Mississippi Medical Center, Jackson

"Diabetic Retinopathy"
Raul E. Valenzuela, Division of Ophthalmology, University of Mississippi Medical Center, Jackson

"Hemodynamic and Angiographic Assessment of Coronary Heart Disease"
Quinton H. Dickerson, Jr., James C. Hays, William H. Rosenblatt, and James L. Crosthwait, Mississippi Heart Institute, St. Dominic Hospital, Jackson

"The Mississippi Head and Neck Cancer Control Network"
Michael E. Jabaley, Director, and Myron W. Lockey, Associate Director, Jackson

"Kidney Transplant Program for Mississippi"
George V. Smith, Pat Etheridge and Richard MacMillan, Kidney Transplant Service, University of Mississippi Medical Center, Jackson

"Mississippi Leads the Way to Improve Maternal/Infant Health Care in the Southeast by Physician/Nurse-Midwife Teams"
Southeastern Regional Council on Development of Nurse-Midwifery, Jackson

"The Program in Family Medicine at the University of Mississippi Medical Center"
W. R. Gillis, H. Woodbridge, W. Treadwell, and J. H. Pfifferling, Department of Family Medicine, University of Mississippi Medical Center, Jackson

"Fiberoptic Endoscopy—Colonoscopy, Esophagoscopy and Gastroduodenoscopy"
Jack B. Campbell, Edward M. Lowicki, and Charles E. Farmer, Jackson

"25 Years of Service to You"
Mississippi Heart Association

"Total Joint Replacements in the Lower Extremities"
Paul S. Derian and W. C. Hopper, Department of Orthopaedic Surgery, University of Mississippi Medical Center, Jackson

"Supracondylar Fractures in Children"
Paul S. Derian and W. C. Hopper, Department of Orthopaedic Surgery, University of Mississippi Medical Center, Jackson

"Mammography"
Elmer J. Harris, James M. Packer, and Robert P. Henderson, Mississippi Baptist Medical Center, Jackson

"Surgery of Coronary Artery Disease"
Henry B. Tyler, St. Dominic Hospital and Mississippi Heart Institute, Jackson

THE TECHNICAL EXHIBIT

The Mississippi State Medical Association presents with pride the 1976 Technical Exhibit. Established firms engaged in the manufacture and distribution of pharmaceuticals, supplies, or equipment, and in providing varied services, will present the exhibits. Visit each exhibit often and discuss products and services with the Professional Service Representatives. Only registered members and guests are admitted. The Technical Exhibit is located in the Delta Hall III, Dogwood and Cottonwood Rooms.

EXHIBITORS	BOOTH
Ames Co., Div. of Miles Labs, Elkhart, IN	23
Bedsole Surgical Supply Co., Inc., Mobile, AL	4
Blue Cross-Blue Shield of MS, Inc., Jackson, MS	1
Boehringer Ingelheim Ltd., Elmsford, NY	17
Bristol Laboratories, Syracuse, NY	30
Ciba Pharmaceuticals, Summit, NJ	35
Cooper Laboratories, Inc., Parsippany, NJ	33
Danal Laboratories, St. Louis, MO	11
Data Professional Corp., Jackson, MS	21 and 22
Deposit Guaranty National Bank, Trust Division, Jackson, MS	13
Dista Products, Indianapolis, IN	48
Jasper Ewing and Sons, Inc., Jackson, MS	12
First Investment Co., Jackson, MS	3
First National Bank of Jackson, Jackson, MS	32
General Medical-Jackson, Jackson, MS	40
Hill Crest Hospital, Birmingham, AL	46
Hoechst-Roussel Pharmaceuticals, Inc., Sommerville, NJ	43
Kremers-Urban Co., Milwaukee, WI	18

Lanier Business Products, Jackson, MS 6
Mallinckrodt, Inc., Hazelwood, MO 41
McNeil Laboratories, Ft. Washington, PA 42
Medical and Corporate Financial, Inc., Jackson, MS 15
Meyer Laboratories, Inc., Ft. Lauderdale, FL 31
Pfizer Laboratories, Doraville, GA 20
W. P. Poythress and Co., Richmond, VA 45
Professional Asso. Lab., Inc., Jackson, MS 5
Professional Planning Associates, Jackson, MS 28
Riverside Hospital, Jackson, MS 8
A. H. Robins Co., Richmond, VA 27
Roche Laboratories, Nutley, NJ 39
Safeguard Business Systems, Tucker, GA 38
Sandoz Pharmaceuticals, East Hanover, NJ 2
Schering Corp., Kenilworth, NJ 37
E. R. Squibb and Sons, Princeton, NJ 14
St. Paul Fire and Marine Insurance Co., St. Paul, MN 26
Systemedics/AMS, Laurel, MS 10
The Travelers Insurance Co.-Medicare, Jackson, MS 44
UAD Laboratories, Inc., Jackson, MS 47
U.S. Air Force, New Orleans, LA 9
USV Pharmaceuticals Corp., Tuckahoe, NY 19
Unifirst Federal Savings and Loan Assoc., Jackson, MS 7
Weight Watchers in Greater MS, Jackson, MS 16

REGISTRATION FOR EXHIBIT PRIZES

Visit the Technical Exhibits often and qualify for the drawing of attractive prizes. Obtain necessary initials as you visit each booth. Drawing for exhibit attendance prizes will be held at MSMA registration on Tuesday and Wednesday at 5:00 p.m.

SCIENTIFIC GRANTS

A. H. Robins Company, Richmond, VA
Eli Lilly and Company, Indianapolis, IN
Schering Laboratories, Kenilworth, NJ
Geigy Pharmaceuticals, Ardsley, NY

ASSISTANCE WITH SCIENTIFIC PROGRAM

These pharmaceutical manufacturers provided financial assistance to the following scientific section programs:

Merck Sharp and Dohme—Section on Medicine
Ross Laboratories—Section on Pediatrics
Flint Laboratories and Heyer-Schulte—Section on Surgery

The Scientific Assembly has been approved for 12 hours of MAFP prescribed credit.

SCIENTIFIC PROGRAM

Sunday, May 2, 1976
Pecan II
Beginning at 3:00 p.m.

James M. Cooper, Tupelo
Chairman

Katherine Aldridge, Hattiesburg
Secretary



DR. COOPER

SHORT COURSE IN:

CHANGING CONCEPTS IN ANESTHESIA
Leonard Fabian, Professor, Department of Anesthesiology, Washington University School of Medicine, St. Louis

---

SCIENTIFIC PROGRAM

Tuesday, May 4, 1976
Pecan I
Beginning at 9:00 a.m.

Milam S. Cotten, Hattiesburg
Chairman

James W. Rayner, Oxford
Secretary



DR. COTTEN

SHORT COURSES IN:

LENS IMPLANTATION:
ARE THERE ANY INDICATIONS?
Robert C. Drews, Associate professor of clinical ophthalmology, Washington University School of Medicine, St. Louis

FACIAL SURGERY—
THE SURGERY OF APPEARANCE
E. Gaylon McCollough, Clinical instructor, Division of Otorhinolaryngology, University of Alabama Medical Center, Birmingham

LENS IMPLANTATION:
INTRACAPSULAR TECHNIQUE
Dr. Drews

COSMETIC BLEPHAROPLASTY
Dr. McCollough

SCIENTIFIC PROGRAM

Tuesday, May 4, 1976
Delta Hall I
Beginning at 9:00 a.m.

Michael E. Jabaley, Jackson
Chairman

Henry B. Tyler, Jackson
Secretary



DR. JABALEY

SHORT COURSES IN:

FLEXOR TENDON INJURIES IN NO-MAN'S LAND: A MOVABLE FEAST
Michael E. Jabaley, Professor and chairman, Division of Plastic Surgery, University of Mississippi Medical Center, Jackson

SILK PURSES AND SOWS' EARS
John E. Hoopes, Professor of plastic surgery, The Johns Hopkins University School of Medicine, Baltimore

MANAGEMENT OF THE CONTAMINATED WOUND
Thomas J. Krizek, Professor of surgery (plastic), Yale University School of Medicine, and chief, section on plastic and reconstructive surgery, Yale-New Haven Medical Center, New Haven, Conn.

SCIENTIFIC PROGRAM

Tuesday, May 4, 1976
Walnut Room
Beginning at 1:30 p.m.

James A. Sheffield, Gulfport
Chairman

Robert L. Abney, III, Jackson
Secretary



DR. SHEFFIELD

SHORT COURSES IN:

"SYMPOSIUM ON BIOETHICAL AND MEDICOLEGAL ASPECTS OF NEONATAL MEDICINE"
MEDICAL, LEGAL AND MORAL ASPECTS OF PERINATOLOGY
Donald M. Sherline, Professor, Department of Ob-Gyn; director of division of maternal-fetal medicine; associate professor of anesthesiology, University of Mississippi Medical Center, Jackson

WHAT ARE THE INDICATIONS FOR DECELERATION OF CARE IN THE NEWBORN PERIOD?
Alfred W. Brann, Jr., Professor of pediatrics and director of newborn medicine, Emory University School of Medicine, Atlanta

MEDICOLEGAL ASPECTS OF NEONATAL CARE
A. Spencer Gilbert, III, Lawyer, Jackson

SCIENTIFIC PROGRAM

Tuesday, May 4, 1976
Southern Pine I and II
Beginning at 1:30 p.m.

Bernard Booth, Jackson
Chairman

Joe M. Ross, Jr., Vicksburg
Secretary



DR. BOOTH

SHORT COURSES IN:

NEWER ASPECTS OF BRONCHODILATOR THERAPY
Don Q. Mitchell, Clinical assistant professor of medicine, University of Mississippi Medical Center, Jackson

ALCOHOLISM
Jack Morgan, Clinical instructor, Department of Psychiatry, University of Tennessee; assistant medical director, Alcohol and Drug Center, Tennessee Psychiatric Center, Memphis

URTICARIA
Philip Lieberman, Associate professor of medicine; chief, division of allergy and clinical immunology, University of Tennessee College of Medicine, Memphis

---

SCIENTIFIC PROGRAM

Tuesday, May 4, 1976
Hickory Room
Beginning at 1:30 p.m.

John Y. Gibson, Jackson
Chairman

Bernard I. Blumenthal,
Jackson
Secretary



DR. GIBSON

SHORT COURSES IN:

NEWBORN GASTROINTESTINAL SYNDROMES
Arvin E. Robinson, Professor and chairman, department of radiology, University of South Alabama Medical Center, Mobile

COMPUTED TOMOGRAPHY OF THE BRAIN—
BASIC PRINCIPLES AND SURVEY OF APPLICATIONS
William F. Russell, Assistant professor, department of radiology, University of Mississippi Medical Center, Jackson

PULMONARY OVERAERATION IN
INFANTS AND CHILDREN
Bernard I. Blumenthal, Assistant professor, department of radiology, University of Mississippi Medical Center, Jackson

ROLE OF RADIOLOGY IN DIAGNOSIS AND TREATMENT OF GASTROINTESTINAL BLEEDING
Edward L. Geiger, Practicing Radiologist, St. Dominic-Jackson Memorial Hospital, Jackson

---

SCIENTIFIC PROGRAM

Wednesday, May 5, 1976
Walnut Room
Beginning at 9:00 a.m.

Ralph L. Brock, McComb
Chairman

Hardy B. Woodbridge, Jr., Jackson
Secretary



DR. BROCK

SHORT COURSES IN:

OFFICE RECORD KEEPING
Marion L. Sigrest, Practicing family physician, Yazoo City

CORRELATION OF CORONARY ARTERY ANATOMY WITH CLINICAL FINDINGS IN CORONARY ARTERY DISEASE
H. Davis Dear, Jr., Director of cardiovascular laboratory, Mississippi Baptist Medical Center, Jackson

VENOUS THROMBOSIS:
COMPLICATIONS AND PREVENTION
Alton Ochsner, Consultant in surgery, Ochsner Clinic and Ochsner Foundation Hospital, New Orleans

SCIENTIFIC PROGRAM

Wednesday, May 5, 1976
Pecan I
Beginning at 1:30 p.m.

I. E. Gaddy, Gulfport
Chairman

Wadie Abraham, Meridian
Secretary



DR. GADDY

SHORT COURSES IN:

INDUCTION OF OVULATION
Gary P. Wood, Assistant professor, Department of Ob-Gyn, University of Arkansas Medical Center, Little Rock

THE MANAGEMENT OF ABNORMAL PAP SMEAR BY CULPOSCOPY
Juan Roman, Assistant professor, Department of Ob-Gyn, University of Arkansas Medical Center, Little Rock

EVALUATION OF THE PATIENT WITH AMENORRHEA
Dr. Wood

SCIENTIFIC PROGRAM

Wednesday, May 5, 1976
Willow II
Beginning at 1:30 p.m.

George J. Taylor, Morton
Chairman

W. E. Riecken, Jr., Jackson
Secretary



DR. TAYLOR

SHORT COURSES IN:

THE MISSISSIPPI REGIONAL TUBERCULOSIS PROGRAM—THE NEW CONCEPT
Lee Reid, Mississippi State Board of Health, Jackson

HYPERTENSION—A COMMUNITY AFFAIR
Joseph A. Wilber, Supervisor, Adult Health Section, Georgia Department of Human Resources, and clinical associate professor of medicine, Emory University School of Medicine, Atlanta

ST. LOUIS ENCEPHALITIS IN 1975—
MORE TO COME IN '76
Kenneth Powell, Epidemiologist, Bureau of Disease Control, State Board of Health, Jackson

OUT OF STATE ESSAYISTS



ALFRED W. BRANN, JR.
Atlanta



E. G. MCCOLLOUGH,
Birmingham



ROBERT C. DREWS,
St. Louis



ALTON OCHSNER,
New Orleans



LEONARD FABIAN,
St. Louis



ARVIN E. ROBINSON,
Mobile



JOHN E. HOOPES,
Baltimore



JOSEPH A. WILBER,
Atlanta



THOMAS J. KRIZEK,
New Haven, Conn.



GARY P. WOOD
Little Rock

MISSISSIPPI PSYCHIATRIC ASSOCIATION

The Mississippi Psychiatric Association will hold a luncheon meeting on Sunday, May 2, at 12:00 noon in Pecan Room I. Stanley Russell of Jackson is president; Barbara Goff of Jackson is president-elect; and James E. Ruff of Jackson is secretary.

UROLOGY SEMINAR

The Mississippi Urological Society will sponsor a urology seminar for family physicians on Sunday, May 2 from 1:00 to 4:00 p.m. in The Holiday Inn's Walnut Room. Speakers and their topics are:

"Hematuria"—James O. Gordon, Tupelo
"Calculi"—W. H. Merrell, Jackson
"Bladder Outlet Obstruction"—Toxie Morris, Hattiesburg
"Scrotal Masses"—Gerald Wessler, Gulfport
"Infertility"—Jack Aldridge, Jackson
"Genitourinary Trauma"—Stanley Wade, Meridian
"Recent Advances in Urology"—W. Lamar Weems, Jackson
Moderator: John W. Evans, Tupelo

Officers of the Mississippi Urological Society are president, W. H. Merrell, and secretary-treasurer, William C. Gates of Columbus.

MISSISSIPPI ASSOCIATION OF PATHOLOGISTS

The Mississippi Association of Pathologists will have a business meeting on Sunday, May 2, from 3:00 to 5:00 p.m. in the Southern Pine I. There will be a scientific session at 9:00 a.m. on Monday, May 3, in the Southern Pine I. Guest speaker will be Dr. Milton Halpern of New York City, former chief medical examiner and professor and chairman of forensic medicine at New York University. Luncheon will follow at noon in Southern Pine II. Officers of the association are president, Van B. Philpot, Jr., of Houston; president-elect, Ben F. Martin, III, of Columbus; and secretary, Julian C. Henderson of Jackson.

MISSISSIPPI UROLOGICAL SOCIETY

The Mississippi Urological Society will hold a business meeting and luncheon on Monday at 12:00 noon in the Hickory Room.

MISSISSIPPI SOCIETY OF ANESTHESIOLOGISTS

The Mississippi Society of Anesthesiologists will meet in the Pecan Room II on Sunday, May 2, at 3:00 p.m. for a business meeting and the MSMA Section on Anesthesiology program at 4:00 p.m. At 5:00 p.m. there will be a cocktail party and dinner will follow at 6:00 p.m. in Pecan Room I. Society officers are James M. Cooper of Tupelo, president, and Katherine Aldridge of Hattiesburg, secretary-treasurer.

DERMATOLOGICAL SEMINAR

The Mississippi Dermatological Society will sponsor a seminar for practicing physicians on Monday, May 3, at 9:00 a.m. in the Walnut Room. The program is:

Introduction—Louis J. Wise, Jackson
Panel Discussion—Ronald R. Lubritz, Hattiesburg, Director
Intermission
Panel Discussion—James M. McQueen, Jackson, Director

Questions from the audience will be answered, according to Dr. Wise, president of the society, and the whole range of dermatological problems will be covered. Other officers are president-elect, Dr. Lubritz; secretary-treasurer, John A. Marascalco of Greenville; and member-at-large, W. Rodney Clement of Gulfport.

MISSISSIPPI ORTHOPAEDIC SOCIETY

The Mississippi Orthopaedic Society will have a scientific meeting and luncheon on Monday, May 3, beginning at 10:30 a.m. in the Willow I and II rooms. Guests speakers and their topics are:

Pediatric Orthopedics—Douglas W. McKay, Washington, D. C.
The Natural History of Degenerative Disc Disease—M. Laurens Rowe, Rochester, N. Y.

Society officers are president, Sidney R. Berry of Jackson; president-elect, Cleveland E. Johnson of Laurel; vice-president, L. B. Yerger of Jackson; and secretary-treasurer, Hugh P. Brown of Jackson.

ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY

The Academy of Facial Plastic and Reconstructive Surgery will host a breakfast on Tuesday, May 4, at 7:30 a.m. in Willow I. During the business session, an organizational meeting will be held and officers elected. The scientific program begins at 8:00 and the speakers and their topics are:

Practical Aspects of Rhinoplasty—Larry Day, Hattiesburg
Surgical Management of Hypopharyngeal and Cervical Esophagus Carcinoma—Myron W. Lockey, Jackson

Dr. J. George Smith of Jackson is serving as meeting chairman.

AMERICAN COLLEGE OF SURGEONS, MISSISSIPPI CHAPTER

The American College of Surgeons, Mississippi Chapter, will sponsor a luncheon on Tuesday, May 4, at 12:00 noon in the Delta Hall II. The scientific program will follow at 1:30 p.m. in the Delta Hall I.

Wound Coverage Problems in Vascular Disease—Thomas J. Krizek, New Haven, Conn.
Reconstructive Surgery of the Breast—John E. Hoopes, Baltimore, MD
Urethral Injuries in Pelvic Fractures—W. Lamar Weems, Jackson, MS

Officers of the college are president, Richard H. Clark, Jr., of Hattiesburg; president-elect, Thomas G. Barnes of Greenville; and secretary, W. Briggs Hopson, Jr., of Vicksburg. ACS officers will meet for breakfast at 7:30 a.m. on May 4 in the Pecan II room.

MISSISSIPPI EENT ASSOCIATION

The Mississippi EENT Association will hold a luncheon and business meeting on Tuesday, May 4, at 12:00 noon in Pecan Room II. Association officers are president, Dan H. Moore, Jr., of Meridian; vice president, Larry H. Day of Hattiesburg; and secretary-treasurer, Ben McCarty, Jr., of Jackson.

MISSISSIPPI SOCIETY OF INTERNAL MEDICINE

The Mississippi Society of Internal Medicine will host a luncheon on Tuesday at 12:00 noon in Willow I. Society president is A. Robert Dill of Columbus and secretary is James C. Hays of Jackson.

FLYING PHYSICIANS ASSOCIATION, MISSISSIPPI CHAPTER

The Mississippi chapter of the Flying Physicians Association, Inc. will host a dutch bar and dinner at the Holiday Inn Downtown's Pecan Room I at 6:30 p.m. on Wednesday. All FPA members and physicians interested in aviation are invited to attend. Lee H. Rogers of Tupelo is president and John J. White of Jackson is secretary of the chapter.

MISSISSIPPI OB-GYN SOCIETY

The Mississippi Ob-Gyn Society will conduct a luncheon meeting on Wednesday, May 5 at 12:00 noon in Pecan II. Society officers are president, Calvin Hull of Jackson; president-elect, Richard Hollis of Amory; vice president, Kenneth Pittman of Jackson; and secretary, Lewis D. Lipscomb of Jackson.

MISSISSIPPI ACADEMY OF FAMILY PHYSICIANS

The Mississippi Academy of Family Physicians will sponsor a luncheon meeting at 12:00 noon on Wednesday, May 5, in Delta Hall I. Guest speaker will be the Honorable Cliff Finch, Governor of Mississippi. Officers of the Mississippi academy are president, Richard T. Furr of Ocean Springs; president-elect, Walter H. Rose of Indianola; vice president, Frank W. Bowen of Carthage; and secretary-treasurer, John M. Estess of Hollandale.

A SHORT COURSE IN TONOMETRY FOR NON-OPHTHALMOLOGISTS

The Mississippi Society for the Prevention of Blindness and the Mississippi EENT Association will sponsor a short course in tonometry for family physicians on Wednesday, May 5, at 3:00 p.m. in the Walnut Room. Those taking the course are eligible for one hour of credit from the American Academy of Family Physicians.

REFERENCE COMMITTEE BREAKFAST

Members of all reference committees of the House of Delegates will meet for breakfast on Monday morning, May 3, in the Hickory Room at 7:00 a.m. Hosts are C. D. Taylor of Pass Christian, speaker, and R. F. Triplett of Jackson, vice speaker. At this important meeting, committee members will be instructed in their duties and conduct of hearings to be held later in the day.

FIFTY YEAR CLUB

The Board of Trustees, sponsors of the association's Fifty Year Club, will honor the half-century plus members at a special luncheon on Wednesday, May 5, in Willow I at 12:00 noon. James O. Gilmore of Oxford, chairman of the Board of Trustees, will preside.

MSMA PAST PRESIDENTS' BREAKFAST

Past presidents of the Mississippi State Medical Association will enjoy a fraternal breakfast on Wednesday morning, May 5, in the Hickory Room at 7:30 a.m. Dr. J. T. Davis of Corinth is host.

TULANE MEDICAL ALUMNI

Medical graduates of Tulane University will be feted at a reception on Monday evening, May 3, in the Pecan Room I from 6:00 to 8:00 p.m. Ms. Wendy B. Kornegay, Medical Alumni Coordinator at Tulane, is aiding in arrangements.

TENNESSEE MEDICAL ALUMNI

Medical alumni of the University of Tennessee will enjoy a reception on Monday evening, May 3, in the Walnut Room from 7:00 to 9:00 p.m. Arrangements are being made by John Sheridan, Director of Alumni Affairs at UT.

OLE MISS MEDICAL ALUMNI

University of Mississippi medical alumni, families and guests will meet on Monday, May 3, at the Holiday Inn Downtown. Alumni registration will be located adjacent to MSMA general registration in the second floor lobby and will be open at 8:00 a.m. where tickets for the evening party will be available. A general business meeting will be conducted at 4:00 p.m. on Monday in the Hickory Room. The cocktail party and banquet will begin at 7:00 p.m. in the Delta Halls I and II. Elmer Nix of Jackson is program planning committee chairman. Committee members are James C. Hays, W. E. Bowlus, Albert L. Meena and Kenneth Reed, all of Jackson. J. V. Ferguson, Jr., of Greenwood, medical alumni president, will preside. President-elect of the alumni association is Charles Farris of New Orleans. The Medical Alumni Guardian Society of the University of Mississippi Foundation will meet at the University Club on Sunday, May 2, at 7 p.m.

MISSISSIPPI FOUNDATION FOR MEDICAL CARE

The Mississippi Foundation for Medical Care will hold its annual meeting on Monday afternoon, May 3, beginning at 1:30 p.m., in Delta Hall I. All members are urged to attend.

MISSISSIPPI NEUROSURGICAL SOCIETY

The Mississippi Neurosurgical Society will sponsor a luncheon and program beginning at 12:30 p.m. on Tuesday, May 4, in Willow II. Dr. Glenn Warren of Jackson is president.

ASSOCIATION BICENTENNIAL PARTY

Members of the Mississippi State Medical Association, their families and guests will enjoy a bicentennial banquet with entertainment from the roaring twenties on Tuesday evening, May 4, in Delta Halls 1 and 2 beginning at 7:00 p.m. There will be a social hour followed by dinner and the Gaslight Road Show of Chicago. Tickets are available from the MSMA office or members of the Auxiliary.

MSMA OFFICERS BREAKFAST

On Tuesday, May 4, at 7:30 a.m. in the Walnut Room the MSMA Board of Trustees, officers and component society presidents and secretaries will hold a breakfast meeting to discuss MSMA organization and activities.

WOMAN'S AUXILIARY TO THE MISSISSIPPI STATE MEDICAL ASSOCIATION

53rd Annual Session The Holiday Inn Downtown

May 2-5, 1976



MRS. HILL



MRS. BROWN

OFFICERS

MRS. EDWARD HILL
Hollandale
President

MRS. W. A. BROWN
Mathiston
President-elect

MRS. W. MONCURE DABNEY
Crystal Springs, Treasurer

Mrs. John Estess
Hollandale
Convention Chairman

Mrs. Cecil Knox, Jr.
Vicksburg
Registration Chairman

Mrs. Carl Nichols
Leland

Mrs. Frank Acree
Greenville

Luncheon Co-chairmen

AUXILIARY

Sunday, May 2, 1976

2:00-6:00 p.m. Registration and Hospitality, Lobby, Lower Level

Monday, May 3, 1976

9:00 a.m.-5:00 p.m. Registration

9:30 a.m. Finance Committee Meeting, Pecan I Room

3:00 p.m. Preconvention Board Meeting, Pecan II

4:30 p.m. Coffee honoring county presidents and state chairmen

12-hour claims
are nothing new.

12-hour relief is.



NEW

Novafed® A Capsules

Each capsule contains pseudo-ephedrine hydrochloride 120 mg. and chlorpheniramine maleate 8 mg.

Controlled-Release Decongestant Plus Antihistamine

It goes the distance.





Clinical studies confirm full 12-hour effectiveness.

For years, patients have heard of drugs providing long-lasting relief. But after six or eight hours, they often run out of relief. And it's too soon to take the next dose.

Now, with Novafed A, Dow introduces a prescription capsule with 12-hour effectiveness in relieving allergy and hay fever symptoms. Placebo-controlled clinical studies show that the high level of decongestant in Novafed A provides relief for as long as 12 hours. At the same time, its antihistamine relieves the patient's itchy eyes and runny nose *without* the excessive dryness of anticholinergic agents.

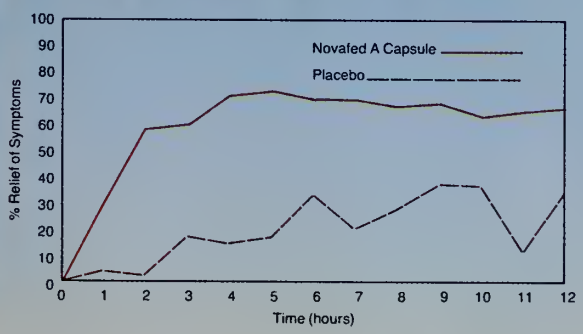
Prompt onset of effect is followed by full 12-hour relief.

(Please refer to the following page for bioavailability studies and prescribing information.)



Patients with severe pollen allergies were tested during hay fever season in a countryside environment and asked to rate severity of five different symptoms on a scale of 1 to 4.

Clinical Study: Degree of Relief from Itchy Eyes and Nose and Throat, Watery Eyes, Runny Nose*



*Unpublished data, Medical Department Files, Dow Pharmaceuticals, The Dow Chemical Company, Indianapolis, Indiana.

DOW®

Specialists in Cough and Cold Care





NEW

Novafed® A Capsules

Each capsule contains pseudoephedrine hydrochloride 120 mg. and chlorpheniramine maleate 8 mg.

Controlled-Release Decongestant Plus Antihistamine

It goes the distance.



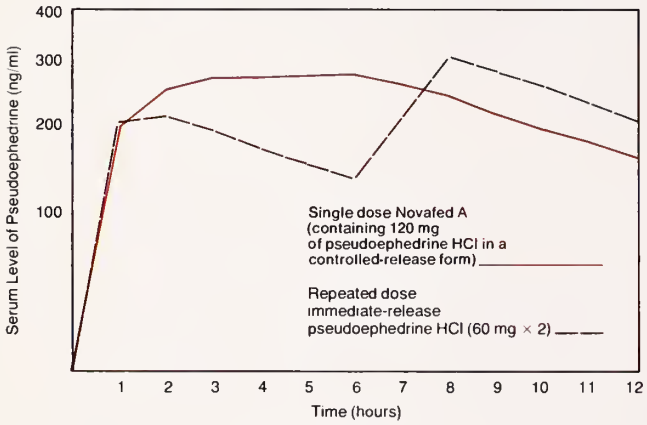
Prompt onset and sustained serum levels over 12 hours.

A bioavailability study confirmed that the sustained 12-hour action of Novafed A was comparable to that of immediate-release medication taken at 6-hour intervals.

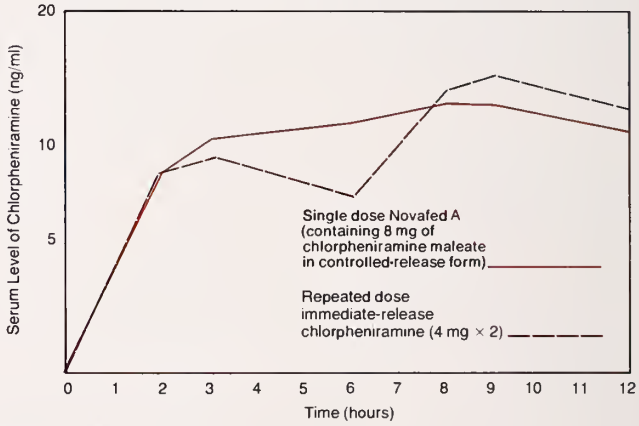
The chart at the left shows the serum levels of pseudoephedrine. Initial serum levels following one Novafed A Capsule were comparable to those following a single dose of 60 mg. pseudoephedrine hydrochloride in an immediate-release form. Serum levels of pseudoephedrine over a 12-hour period following a single dose of Novafed A were also comparable to those obtained by an immediate-release form taken every 6 hours.

The chart at the right shows the serum levels of chlorpheniramine. Initial serum levels following one Novafed A Capsule were comparable to those following a single dose of 4 mg. chlorpheniramine maleate in an immediate-release form. Serum levels of chlorpheniramine over a 12-hour period following a single dose of Novafed A were also comparable to those obtained by an immediate-release form taken every 6 hours.

Comparison of Mean Serum Levels of Pseudoephedrine Following Novafed A and an Immediate-Release Reference Formulation*



Comparison of Mean Serum Levels of Chlorpheniramine Following Novafed A and an Immediate-Release Reference Formulation*



*Unpublished data, Medical Department Files, Dow Pharmaceuticals, The Dow Chemical Company, Indianapolis, Indiana.

DESCRIPTION: Each NOVAFED A capsule contains 120 mg. of pseudoephedrine hydrochloride and 8 mg. of chlorpheniramine maleate. The specially formulated pellets in each capsule are designed to provide continuous therapeutic effect for about 12 hours. Nearly one-half of the active ingredients is released soon after administration and the remainder is released slowly over the remaining time period.

ACTIONS: NOVAFED A combines the action of a nasal decongestant, pseudoephedrine hydrochloride, and an antihistamine, chlorpheniramine maleate. These ingredients are combined to provide prompt and sustained nasal and upper respiratory decongestant and antihistaminic action.

INDICATIONS: NOVAFED A is indicated for the relief of nasal congestion and eustachian tube congestion associated with the common cold, sinusitis and acute upper respiratory infections. It is also indicated for perennial and seasonal allergic rhinitis, vasomotor rhinitis, allergic conjunctivitis due to inhalant allergens and foods and for mild, uncomplicated allergic skin manifestations of urticaria and angioedema. Decongestants in combination with antihistamines have been used for many years to relieve eustachian tube congestion associated with acute eustachian salpingitis, aerotitis media, acute otitis media and serous otitis media. NOVAFED A may be given concurrently, when indicated, with analgesics and antibiotics.

CONTRAINDICATIONS: Symphathomimetic amines are contraindicated in patients with severe hypertension, severe coronary artery disease, and in patients on MAO inhibitor therapy. Antihistamines are contraindicated in patients with narrow-angle glaucoma, urinary retention, peptic ulcer, during an asthmatic attack, and in patients receiving MAO inhibitors.

Children under 12: NOVAFED A controlled-release capsules should not be used in children less than 12 years of age.

Nursing Mothers: Pseudoephedrine is contraindicated in nursing mothers because of the higher than usual risk for infants from sympathomimetic amines.

Hypersensitivity: This drug is contraindicated in patients with hypersensitivity or idiosyncrasy to sympathomimetic amines or antihistamines. Patient idiosyncrasy to adrenergic agents may be manifested by insomnia, dizziness, weakness, tremor or arrhythmias.

WARNINGS: Sympathomimetic amines should be used judiciously and sparingly in patients with hypertension, diabetes mellitus, ischemic heart disease, increased intraocular pressure, hyperthyroidism, or prostatic hypertrophy. Sympathomimetics may produce central nervous system stimulation and convulsions or cardiovascular collapse with accompanying hypotension.

Antihistamines may impair mental and physical abilities required for the performance of potentially hazardous tasks, such as driving a vehicle or operating machinery, and mental alertness in children. Chlorpheniramine maleate has an atropine-like action and should be used with caution in patients with increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension or in patients with a history of bronchial asthma.

Do not exceed recommended dosage.

Use in Pregnancy: The safety of pseudoephedrine for use during pregnancy has not been established.

Use in Elderly: The elderly (60 years and older) are more likely to have adverse reaction to sympathomimetics. Overdosage of sympathomimetics in this age group may cause hallucinations, convulsions, CNS depression, and death. Therefore, safe use of a short-acting sympathomimetic should be demonstrated in the individual elderly patient before considering the use of a sustained-action formulation.

PRECAUTIONS: This drug should be used with caution in patients with diabetes, hypertension, cardiovascular disease and hyperreactivity to ephedrine. The antihistaminic may cause drowsiness and ambulatory patients who operate machinery or motor vehicles should be cautioned accordingly.

ADVERSE REACTIONS: Hyperreactive individuals may display ephedrine-like reactions such as tachycardia, palpitations, headache, dizziness, or nausea. Patients sensitive to antihistamines may experience mild sedation.

Sympathomimetic drugs have been associated with certain untoward reactions including fear, anxiety, tenseness, restlessness, tremor, weakness, pallor, respiratory difficulty, dysuria, insomnia, hallucinations, convulsions, CNS depression, arrhythmias, and cardiovascular collapse with hypotension.

Possible side effects of antihistamines are drowsiness, restlessness, dizziness, weakness, dry mouth, anorexia, nausea, headache and nervousness, blurring of vision, heartburn, dysuria and very rarely, dermatitis.

DRUG INTERACTIONS: MAO inhibitors and beta adrenergic blockers increase the effect of sympathomimetics. Sympathomimetics may reduce the antihypertensive effects of methyldopa, mecamylamine, reserpine and veratrum alkaloids. Concomitant use of antihistamines with alcohol, tricyclic antidepressants, barbiturates and other central nervous system depressants may have an additive effect.

DOSAGE AND ADMINISTRATION: One capsule every 12 hours. Do not give to children under 12 years of age.

CAUTION: Federal law prohibits dispensing without prescription.

HOW SUPPLIED: NOVAFED A is supplied in red and orange colored hard gelatin capsules, monogrammed with the Dow diamond followed by the number 109, in bottles of 100.

DOW

DOW PHARMACEUTICALS
The Dow Chemical Company
Indianapolis, IN 46268

Specialists in cough and cold care

Tuesday, May 4, 1976

9:00 a.m. Coffee

9:30 a.m. General Session, Southern Pine I and II
- Invocation
- Welcome
- Response
- Introductions
- Greetings
  - Dr. Jack A. Atkinson, President, MSMA
  - Dr. Lyne S. Gamble, President-elect, MSMA
  - Mrs. Lee E. Rice, First Vice-president, AMA Auxiliary, Boulder, CO
- Guest Speaker—Mrs. Rice
- Roll Call
- Minutes
- Reports
- Appointment of Delegates to the AMA Auxiliary Annual Meeting
- Business
- Election of Officers
- Installation of Officers
- Memorial Service
- Courtesy Resolutions
- Adjournment

1:00 p.m. Luncheon, Country Club of Jackson
- Invocation
- Introduction—Dr. Jack A. Atkinson
  - Guest speaker—Dr. Max Parrott, President, AMA
- Presentation of Officers
- Awards
- Adjournment
- Style Show

3:30 p.m. Postconvention Board Meeting, Pecan I

Wednesday, May 5, 1976

9:30 a.m. Past Presidents' Breakfast, Pecan II

10:30 a.m. Working session for state chairmen, county presidents and county chairmen, Southern Pine II

Please note: The AMA-ERF Booth at State Conventions will feature Mr. Lawrence Hickey from Colorado Springs, Colorado. He will display authenic hand-made Indian jewelry for prices ranging from modest to investment. Forty per cent of the total sales will go to AMA-ERF.

MSMA Sponsors Big Annual Session Party to Celebrate the Bicentennial

The nation's 200th birthday shares billing with the roaring 20's when MSMA returns to the big all-inclusive party format to help celebrate the bicentennial during the association's 108th Annual Session.

Set for Tuesday evening, May 4, at 7:00 p.m. in the Downtown Holiday Inn's Delta Rooms I and II, the party will begin with a social hour, featuring 10¢ beer. Dinner will follow and the evening's highlight will be entertainment by the Gaslight Road Show. Many MSMA members will remember the Road Show from a former appearance at an annual session in Jackson.

The show features four lovely flappers (who all sing and dance) from the speakeasy room of the famous Gaslight Club in Chicago. Five great jazz musicians provide the musical fun and frolic of the 20's. Dance music will be featured between shows.

Tickets will be $15.00 per person and may be purchased in advance from the MSMA headquarters office or the Auxiliary to MSMA members. Good food, fellowship and fun will be the bill of fare. Seating is limited, so send for your tickets now!





Handbook of the House of Delegates

Mississippi State Medical Association
108th Annual Session
May 3-6, 1976

HANDBOOK INFORMATION

The speaker and vice speaker of the House of Delegates herewith present for the information of all members those reports and resolutions as have been received for publication in advance of the 108th Annual Session. It is the intent of this advance publication to inform the membership and to afford all concerned the opportunity to confer with delegates over any aspects of the reports and resolutions.

No report or resolution herein becomes official or a statement of policy until formally presented to the House of Delegates and acted upon at the annual session.

C. D. Taylor, Jr.
Speaker
R. Faser Triplett
Vice Speaker

SUPPLEMENTAL REPORT A OF THE SECRETARY-TREASURER

Vacancies in Elected Offices. Effective May 6, 1976, there will occur 27 vacancies in elected offices in the association by reason of expiration of prescribed terms of service. In accordance with the bylaws the nominating committee will be asked to deliberate, consult with colleagues, and make nominations to the House of Delegates for consideration and voting to elect successors or to re-elect incumbents. The nominating committee will hold an open meeting on Wednesday, May 5, 1976, for this purpose.

Eligibility. To be nominated for office in the association, a nominee must have been a member for two years, be in present good standing as a member, and must have attended one of the past two or current annual sessions.

Vacancies for Nomination. Following is the listing of vacancies that will occur during the 108th Annual Session as well as requirements for nominations and identity of incumbents:

President-Elect

Nominate three, no two of whom may be from the same county, elect one.

Vice-President

Nominate three for the northern area, three for the mid-state area, and three for the southern area. Elect one for each area.

Secretary-Treasurer

Term 1976-79. Nominate three, elect one. Incumbent: James P. Spell, Jackson.

Delegate to AMA

Term Jan. 1, 1977-Dec. 31, 1978. Nominate two, elect one. Incumbent: Joseph B. Rogers, Biloxi.

Alternate Delegate to AMA

Term Jan. 1, 1977-Dec. 31, 1978. Nominate two, elect one. Incumbent: Paul B. Brumby, Lexington.

Editor

Term 1976-79. Nominate three, elect one. Incumbent: W. Moncure Dabney, Crystal Springs.

Associate Editor

Term 1976-78. Nominate two, elect one. Incumbent: George H. Martin, Vicksburg.

*Board of Trustees, Districts 1, 2 and 3**

Terms 1976-79. Nominate two for each district, elect one for each district. Incumbents: Whitman B. Johnson, Clarksdale, District 1; James O. Gilmore (ineligible for re-election by reason of serving two consecutive terms), Oxford, District 2; and Robert S. Caldwell, Tupelo, District 3.

Council on Budget and Finance

Terms 1976-79. Nominate four, elect two, two vacancies. Incumbents: Walter H. Rose, Indianola (ineligible for re-election by reason of serving two consecutive terms); and Sidney O. Graves, Natchez.

* Note: Amendments are before the House which if adopted would change the several councils' composition. See Report of Council on Constitution and By-Laws.

HOUSE OF DELEGATES / Continued

Council on Constitution and By-Laws

Term 1976-79. Nominate two, elect one. Incumbent: Mary J. Ward, Corinth.

*Judicial Council, Districts 7, 8 and 9**

Terms 1976-79. Nominate two for each district, elect one for each district. Incumbents: William E. Weems, Laurel, District 7; Wendell B. Holmes, McComb, District 8; and James T. Thompson (ineligible for re-election by reason of serving two consecutive terms), Moss Point, District 9.

*Council on Legislation, Districts 4, 5 and 6**

Terms 1976-79. Nominate two for each district, elect one for each district. Incumbents: Ed Pennington, Ackerman, District 4; John G. Caden, Jr. (ineligible for re-election by reason of serving two consecutive terms), Jackson, District 5; and George L. Arrington, Jr., Meridian, District 6.

*Council on Medical Education**

Term 1976-79. Nominate two, elect one. Incumbent: Charles N. Floyd (ineligible for re-election by reason of serving two consecutive terms), Gulfport.

*Council on Medical Service, Districts 7, 8 and 9**

Terms 1976-79. Nominate two for each district, elect one for each district. Incumbents: David M. Owen, Hattiesburg, District 7; Joseph C. Hillman, Brookhaven, District 8; and Bedford F. Floyd, Jr. (ineligible for re-election by reason of serving two consecutive terms), Gulfport, District 9.

Mississippi State Board of Health

Nominate 6, elect 3 for appointment of one by the Governor to fill the unexpired term (December 31, 1977) of Dr. Joseph G. McKinnon (deceased), Public Health District 6 representing: Covington, Forrest, George, Greene, Hancock, Harrison, Jackson, Jeff Davis, Jones, Lamar, Lawrence, Marion, Pearl River, Perry, Simpson, Stone, and Wayne Counties.

REPORT OF THE DELEGATES TO AMA

1975 Clinical Meeting. The professional liability insurance crisis and reorganization dominated the Clinical Session of the American Medical Association conducted for the first time in Hawaii.

The Board of Trustees reported on efforts to improve and stabilize the medical liability climate to include incorporation of a national reinsurance company to reinforce the efforts of state "captive programs" to provide professional liability coverage. Additionally, the Board noted the initiation of a major public and professional communications campaign aimed at improving the medical liability climate and announced plans to continue to explore alternatives to the court system for resolving claims. In related action delegates rejected a resolution asking that all physicians cease purchasing professional liability insurance noting that "failure to purchase professional liability insurance exposes a physician to unlimited liability in most states with no apparent legal mechanism available to protect personal assets."

It was back to the drawing board for the AMA's Council on Long Range Planning and Development as most of the council's recommendations for reorganizing the AMA were met with strong rebuff. In a series of 21 recommendations the council urged making the state medical societies—and not the individual M.D.—the basic AMA membership unit; revising the formula for representation in the House of Delegates so that, essentially, the larger states would lose delegates and smaller states would gain, as would the specialty societies, housestaff and students; create a new category of affiliate membership for the national specialty societies and "other" physician organizations; and cutting back to eight standing councils that would report to the Board of Trustees.

The House of Delegates directed that the AMA remain a federation of state medical societies; that proportional representation be maintained; that the specialty councils be retained; and that the eight standing councils report to the house, not the board.

Of particular interest to Mississippi was a Council on Medical Service report announcing that the council would study and report at the 1976 Annual Session on the effect Medicare and Medicaid reimbursement policies have on distribution of physicians. The council's activity in this regard was based on a resolution from Mississippi at the 1975 Annual Session calling for more equitable reimbursement under Medicare between the states. In other related action concerning the Medicare and Medicaid programs the House strongly criticized the use of "economic indexing" to limit fees to physicians treating Medicare patients and called for deletion of patient and physician names and Social Security numbers from the Social Security Administration's Uniform Health Data Abstract.

A controversy at Chicago's Cook County Hospital echoed in Hawaii and the House of Delegates voted down a resolution to have the AMA investigate the issues surrounding an 11 day housestaff strike. The Interns and Residents Session had approved the

resolution. However, after testimony from officers of the Chicago Medical Society that the society had investigated the matter thoroughly and found no justification for the strike, the House disapproved the resolution. On a similar matter the House of Delegates recognized the right of interns and residents to do collective bargaining stating that interns and residents are both employees and students and thus should have the right to organize and bargain for contracts with hospitals. The House further urged state and county medical societies to assist or represent interns, residents and attending physicians in resolving disputes with hospitals.

The House turned back an attempt to withdraw support from the AMA-sponsored national health insurance (NHI) plan, but agreed to work for a private-sector catastrophic health insurance program with the insurance industry. The Louisiana delegation introduced a resolution to withdraw support from H.R. 6222, the AMA sponsored health insurance plan, stating that most delegates were opposed to any form of NHI. Many delegates agreed, but said that AMA's strategy should be to support an acceptable plan to help defeat mandatory, federally funded proposals.

In other actions the House of Delegates acted to expand AMA legislative action efforts to include participation by state and county medical societies; refused to adopt recommendations from the Medical Student Business Session that the AMA support both elimination of capitation and adoption of a voluntary service linked financial aid program for all medical students; established an ad hoc committee to undertake a crash program to investigate medical discipline nationwide; supported enactment of less restrictive federal regulations governing the performance of voluntary sterilization paid for by the Medicaid program; urged state and local medical societies to work with appropriate local health planning bodies to assist rural communities in a logical service area to coordinate and share their health resources on a regional basis; and stated that compensation of physicians for utilization review of inpatient care is a legitimate expense and should be included in all hospital rates and reimbursable costs regardless of who is paying the patient's bill.

REPORT OF THE BOARD OF TRUSTEES

Organization and Duties—The Board of Trustees is the executive and governing body of the association during vacation of the House of Delegates. It is additionally charged with duties and responsibilities prescribed by law for directors of corporations. In the discharge of these duties the Board shall have conducted four meetings during the 1975-76 association year and met daily during the annual session as required by the association's by-laws. Eight officers sit with the Board of Trustees at all meetings. They are the president, president-elect, immediate past-president, secretary-treasurer, speaker, vice-speaker and the two AMA delegates. Based on action by the House of Delegates at the 107th Annual Session, the Board was expanded this past year to include an additional trustee from District 5 and the president and immediate past-president.

This annual report includes actions on matters referred to the Board by the House of Delegates and items relating to the management and policy functions which are among the Board's responsibilities.

Referrals from the House of Delegates—Matters referred to the Board of Trustees at the 107th Annual Session, 1975, and actions by the House requiring further consideration and implementation include:

(1) Amendments to the MSMA Constitution and By-Laws. An amendment to the MSMA Constitution and By-Laws dealing with equalization of MSMA membership within association districts is "on the table" for action at the 108th Annual Session. Copies of the amendment were furnished to all component medical societies 60 days prior to the annual session as required by the constitution and by-laws. Another amendment scheduled to be considered at the 108th Annual Session deals with composition of the Council on Medical Education. Both amendments are the subject of a report from the Council on Constitution and By-Laws.

The following amendments to the MSMA Constitution and By-Laws adopted at the 107th Annual Session have been implemented:

(a) Nominees for election to office will have attended one of the past two or current annual sessions.

(b) Two trustees are elected to the Board of Trustees from District 5.

(c) The president and immediate past-president are voting members of the Board of Trustees.

(d) Trustees and council members will serve no more than two consecutive three-year terms and after serving six consecutive years are ineligible for re-election to the same body for six years.

(e) A Section on Radiology has been established as one of the scientific sections of the association. The association now has scientific sections on Ob-Gyn, Medicine, Surgery, Family Practice, Preventive Medicine, Pediatrics, EENT, Anesthesiology and Radiology.

(2) Physicians Professional Liability Insurance Program. In "Supplemental Report E—Physicians Professional Liability Insurance Program" the Board and the Committee on Professional Liability Insurance recommended and the House of Delegates approved an extensive legislative program to change the malpractice legal system and study of alternatives to the liability insurance market. Both of these recommendations were the subjects of a special called session of the MSMA House of Delegates on Oct. 23, 1975, the transactions of which are reported in the April 1976 issue of the JOURNAL MSMA.

(3) Chiropractors. In "Supplemental Report C of the Board of Trustees—Chiropractors" the Board recommended and the House of Delegates approved that the association initiate necessary legal action to terminate apparent practices of chiropractors in the state which violate provisions of the chiropractic licensing act and result in the practice of medicine without a license to the detriment of the public's health. Based upon contributions from some 900 MSMA members, legal action in this regard was initiated and the case is presently in the court.

(4) Resolution No. 4—Equalize Payment for Physicians' Services Under Medicare. This resolution urged MSMA and the American Medical Association to go on record as supporting the adjustment of payment of professional fees under the Medicare program to make such fees more equal between Mississippi and other states. The resolution was introduced at the June 1975 meeting of the AMA House of Delegates by our Mississippi delegates and after amendment the following resolution was adopted by the AMA—*"Resolved,* that the AMA reaffirm its long-standing position that government programs which pay for physicians' services should base their payment on physicians' usual, customary and reasonable charges; and be it further *Resolved,* that the Council on Medical Service examine Titles XVIII and XIX to determine the status of these programs with respect to their paying physicians' usual, customary and reasonable charges and the effect, if any, their reimbursement policies are having on the distribution of physician. . . ." The latter resolve was specifically added by our Mississippi delegates after it became apparent that the AMA House of Delegates was not going to amend its policy on physician reimbursement based on "usual, customary and reasonable charges" and the report of the AMA Council on Medical Service will be made at the AMA June 1976 meeting.

(5) Resolution No. 5—Medical Public Relations Program. This resolution directed the association to furnish guidance and urge each of the component medical societies to establish meaningful contact with the local press to implement a medical public relations program. A letter was sent to the president and secretary of each component society urging them to establish a committee on medical public relations. A "How to Establish a Media Relations Program" booklet was also furnished to the component societies and we have offered the assistance of MSMA staff in this regard.

(6) Resolution No. 7—Inclusion of Coverage of Psychiatric Disorders in Health Insurance Policies. This resolution directed the association to support legislation requiring inclusion of coverage of psychiatric disorders in health insurance policies sold in Mississippi and is a subject in a report from the Board concerning 1976 legislative activities.

(7) Resolution No. 12—Reaffirmation of Position Relative to Use of Drugs by Optometrists. This resolution reaffirmed the association's opposition to legislation permitting the use of drugs by optometrists and is a subject in a report from the Board concerning 1976 legislative activities.

(8) Compensation of Elected MSMA Officers and Strengthening the Component Societies. Based on study and recommendation by a special committee the House of Delegates directed the following at the 107th Annual Session concerning compensation of elected MSMA officers and strengthening the component societies:

1. MSMA will provide speakers for component medical society meetings to present medical socioeconomic subjects desired by the society.

2. MSMA will provide clerical assistance with respect to sending out meeting notices for any component society that requests such assistance.

3. Upon request, MSMA will assist the com-

ponent medical societies in arranging meetings or programs that offer continuing medical education accreditation for those in attendance.

4. MSMA will sponsor an annual workshop at meetings of the association for all component medical society presidents and secretaries to discuss the role of the component medical society and areas for strengthening that role.

5. Each MSMA trustee is encouraged to annually visit the component societies in his association district.

6. Each component medical society is encouraged to conduct an annual "legislative night" for the purpose of discussing health care issues with local members of the Mississippi legislature.

7. MSMA will provide all component society officers with a complete summary of action by the House of Delegates following each annual session.

8. The president, president-elect, vice presidents and secretary-treasurer will be reimbursed for travel expenses incurred in visiting the component societies.

9. The president's honorarium is increased from $1,000 to $1,500.

Items 1-6 were conveyed to the president and secretary of each component society by personal letter and in this connection a form was enclosed for the component society to use to invite the district trustee to a meeting of the society. Item 7 was forwarded to the president and secretary of each component society immediately following the 107th Annual Session. Items 8-9 have been implemented as MSMA fiscal policy.

CHAMPUS—The association began its 20th year as fiscal administrator for CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) in 1976. CHAMPUS, which is directed by the Department of Defense, implemented dramatic cutbacks in benefits and professional reimbursement procedures during the past year for announced reasons of budget constraint. Of particular concern to the medical profession effective Jan. 1, 1976, the program began reimbursing participating physicians at the 75th percentile of usual, customary and reasonable charges in a state. The program had been making payment based on the 90th percentile. A 14-member physician committee serves as the review committee for CHAMPUS in Mississippi. The program continued to grow during 1975 with an increase in both claim and dollar volume.

Insurance Programs—The association continues to sponsor a professional liability insurance program with the St. Paul Companies and general accident, disability, health and life programs with the Continental Casualty Company. The latter is administered by Thomas Yates and Company of Jackson. The Board monitors the several programs.

Legislative Program—A new state administration was inaugurated in Jackson during January 1976. The Council on Legislation has met several times over the past months for the purpose of organizing and monitoring the association's legislative program. The program dealt with the professional liability insurance crisis and other matters based on prior actions of the House of Delegates. A full report will be made in this regard at the annual session.

Public Law 93-641—Public Law 93-641, the "National Health Planning and Resources Development Act of 1974" was the subject of a report to the House of Delegates at the 107th Annual Session. Implementation of this law has proceeded during the past year in Mississippi and other states. Public Law 93-641 combines and expands the health planning and funding functions of the Regional Medical, Comprehensive Health Planning and Hill-Burton programs. Criticism of the law has been directed at its apparent placing of complete control of health planning and funding prerogatives in the hands of the Secretary of H.E.W. and the placing of administrative responsibility for carrying out the Secretary's guidelines and directives in this regard in the hands of "consumer" dominated boards.

In Mississippi during the past year two private corporations were formed and competed for designation as the state's Health System Agency under Public Law 93-641. They were the Mississippi Health Improvement Corporation and the Mississippi Health Systems Agency. Based upon careful consideration of the two applicants' credentials and stated plans for operation, the Board accepted an invitation from the Mississippi Health Improvement Corporation to endorse its application for funding as the Health Systems Agency for Mississippi. The Health Systems Agency for Mississippi will more than likely be designated by the Secretary of the H.E.W., after consideration of the governor's recommendations in this regard, by the time of the MSMA annual session.

In addition to the Health System Agency for Mississippi, Public Law 93-641 requires a "State Health Planning and Development Agency" for the state. This is to be a state agency designated by the

governor with the approval of the Secretary of H.E.W. At this time a number of state agencies and the Governor's Office of Comprehensive Health Planning have been mentioned as the State Health Planning and Development Agency. Regulations and guidelines governing the operations of "State Health Planning and Development Agencies" have not been issued by the Secretary of H.E.W. and there is merit in awaiting these before a State Planning and Development Agency is named. After careful consideration of the credentials and present operational capacity of the several state agencies mentioned as potentially qualified to be the State Health Planning and Development Agency, the Board has recommended that the Mississippi State Board of Health be designated this agency.

MSMA/Mississippi Bar Association Liaison Committee—The Board is pleased to note the reactivation of the MSMA/Mississippi Bar Association Liaison Committee during the past year. This committee conducted very important and meaningful work on professional liability legislation. The committee has encouraged activation of local physician/attorney committees for the purpose of discussing matters of mutual concern and we wish to encourage implementation of this recommendation by the component societies of the association. The committee will undertake a reappraisal and updating of the "Mississippi Interprofessional Code for Physicians and Attorneys" as its next project. Members of the committee during the past year were: Jack A. Atkinson, Co-chairman, Brookhaven; Lyne S. Gamble, Greenville; Charles R. Jenkins, Laurel; Sidney O. Graves, Natchez; George D. Purvis, Jackson; Martin B. Harthcock, Jr., Jackson, physicians; and Curtis Coker, Chairman, Jackson; Dixon Pyles, Jackson; Ernest W. Graves, Laurel; Louis G. Baine, Jackson; Lampton O. Williams, Poplarville; Alfred E. Lee, M.D., Oxford, attorneys.

History of the Mississippi State Medical Association—The Board has previously announced plans to update and publish a new edition of the "History of The Mississippi State Medical Association." The history is to be published during this "Bicentennial Year." It will be a memorial to the late Dr. James Grant Thompson of Jackson, a former president of the association and author of the last edition of the "History of the Mississippi State Medical Association."

Annual Registration of Physicians' Licenses—During the past year the Board officially expressed concern to the Mississippi State Board of Health about the implementation of Section 73-27-12, Mississippi Code 1972, Annotated. It had been the Board's impression that this statute provided for the annual registration of physicians' licenses as opposed to annual renewal of such licenses. The Board is happy to report the concurrence of the Mississippi State Board of Health in this view.

Gulf Coast Family Health Foundation—Based upon a study by the Singing River Medical Society and request for association support the Board joined the society in opposing funding of an initial development grant (HMO) for the Gulf Coast Family Health Foundation last year. The Board is happy to note that based on opposition to this project the sponsors withdrew their application.

Committee on Peer Review—The Committee on Peer Review is a constitutional committee of the association charged with the work of peer review . . ." including but not limited to resolution of differences between patient and physician, review of the quality of medical care, adequacy and/or reasonableness of fees, whether due or paid from private or public sources, utilization of health care resources and liaison with private and public sources of medical care financing. . . ." During the past year the committee conducted its routine functions and also at the request of the Mississippi Medicaid Commission conducted peer review of the quality and efficiency of services provided by physicians receiving more than $100,000 annually in Medicaid payments. Coincidently, the timing of the committee's Medicaid review project coincided with adverse national publicity concerning Medicaid payments to physicians and the release of the annual Mississippi Medicaid Commission's report concerning payments to health providers. The committee's report on the medical review project was generally favorable and had a positive effect on Medicaid publicity concerning payments to physicians in Mississippi. The Board wishes to particularly bring the work of this committee during this past year to the attention of the House of Delegates. Members of the committee have devoted many hours to work that has benefitted both the medical profession and the public in Mississippi. Members of the committee are: Ralph L. Brock, Chairman; William B. Hopson, Jr.; Richard C. Fleming, Jr.; James M. Dabbs; J. Kinabrew Williams; Bobby F. King; James V. Ferguson, Jr.; John R. Lovelace; Paul E. Mink; and Ex-Officio members—Jack A. Atkinson and Lyne S. Gamble.

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

FOR LONG-TERM CONTROL OF HYPERTENSION*

Serum K^+ and BUN should be checked periodically. (See Warnings Section.)



Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Warning**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

***Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F Co., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation



HELP STOP THE TEARS

of colic, diarrhea or similar malady

USE LOMA LINDA'S i-SOYALAC

i-Soyalac and regular Soyalac are palatable, readily digestible and assimilated. It simulates human milk in appearance, taste and texture. It is complete with vitamins and minerals. It is suitable for all infants and children. Soyalac is especially recommended by physicians for children who are sensitive to or cannot tolerate cow's milk.

For nearly a quarter of a century, Soyalac has proven its value in promoting growth and development – as shown by extensive clinical data.

Available without carrageenan in: SOYALAC Liquid Concentrate, SOYALAC Powder and i-SOYALAC Liquid Concentrate.

ow in 32 oz. size. Ready-to-Serve

Send to: Loma Linda Foods
Medical Products Division
Riverside, Calif. 92505

SJ-4

Please send me free sample and literature.

Name_____

Address_____

City_____

State_____ Zip_____

Or a simple note on your prescription form will do.



i-SOYALAC contains no corn products.

Mississippi Foundation for Medical Care—The Mississippi Foundation for Medical Care became a fully operational "Conditional PSRO" during June of 1975. The association maintains close liaison with the MFMC and serves under contract as the data processor for the MFMC. The MFMC will hold its annual membership meeting in conjunction with the 108th Annual Session.

Mississippi Medical Political Action Committee (MPAC)—Based on action by the House of Delegates at the 106th Annual Session, MPAC supported candidates for state office during the 1975 Mississippi elections. Seventy-five per cent of the legislative candidates supported by MPAC were elected. Candidates were supported based on local support and/or their voting record during the 1972-1976 Mississippi Legislative Session. MPAC continued to grow in membership during 1975.

Committee on Publications—THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION concluded its 16th year of continuous publication in 1975. The content of the JOURNAL MSMA continues solidly around Mississippi medicine and the journal serves as the association's prime communication mechanism with the membership. Usefulness of the journal was confirmed by favorable results of a membership survey conducted in the fall of 1975. The survey shows that some 75 per cent of the membership read the journal on a regular basis. Readers indicated a desire for more practical scientific articles and more MSMA news. We will meet this request.

Total pages in Volume XVI, 1975, were down from 1974 reflecting fewer national ads and continuing efforts to produce a smaller book to try to cut printing and postage costs. These efforts plus an increased amount of local advertising have helped to offset increasing printing and paper costs. The Committee on Publications voted at its annual meeting to raise the rates for national advertising by 10 per cent to bring JMSMA rates in line with other southern states and to generate additional revenues.

Among services the journal provides the membership are: complete program of the annual sessions; handbook and proceedings of the House of Delegates; and regular listing of component medical society officers and meeting dates.

The Board wishes to acknowledge special appreciation to the editors and the Committee on Publications in the production of this vital membership service.

REPORT OF THE COUNCIL ON SCIENTIFIC ASSEMBLY

Organization and Duties—The Council on Scientific Assembly is a constitutional body of the House of Delegates charged with the responsibility of planning the annual session of the association to include all scientific activities, programming, and the scheduling of annual session events. The council membership consists of the chairmen and secretaries of the nine scientific sections and the secretary-treasurer of the association, a total of 19 members.

108th Annual Session—Planning and organization of the 108th Annual Session was initiated in the summer of 1975. The condensed format conducted at the 107th Annual Session will be continued this year which means that the final session of the House of Delegates will again meet on Thursday morning and several scientific sections will meet simultaneously. To the extent possible, conflicts in schedules and programming have been eliminated, although as a practical matter, such total elimination is not possible. In some instances, the council has requested and placed essayists from various specialty societies not represented in the Scientific Assembly before section audiences. Postgraduate credit from the AMA and American Academy of Family Physicians has been applied for.

We are gratified that at the present annual session, numerous specialty societies have related or concurrent meetings with us. Three medical alumni groups have fraternal and social occasions during convention week, and various nonscientific but medically related bodies will meet during May 3-6. Added postgraduate attractions this year include a Sunday afternoon urology seminar and a Monday dermatological program. We continue to believe that providing for and encouraging these related meetings increases the attractiveness of the annual session to the membership and benefits attendance. We are glad to continue support of the Auxiliary concurrent annual session, and the Auxiliary will again host the hospitality booth on Sunday afternoon to greet and welcome convention goers.

The council voted to return to the previous MSMA party format which included social hour, dinner and entertainment. It was decided to hold the MSMA fellowship party on Tuesday night, May 4. Entertainment will be the Gaslight Road Show from Chicago.

Scientific and Technical Exhibits—Your council is grateful for the participation of our scientific and technical exhibitors in this 108th Annual Session

(Turn to page 126)

Proceedings of the House of Delegates

Special Session
October 23, 1975
Jackson, Mississippi

A SPECIAL SESSION of the House of Delegates was convened in pursuance to lawful notice given, on October 23, 1975, at Primos Northgate Convention Center, Jackson, Mississippi, at 10:00 a.m. by Dr. Jack A. Atkinson of Brookhaven, president, and the Board of Trustees.

After extending greetings, Dr. Atkinson presented the vice speaker, Dr. R. Faser Triplett of Jackson and the speaker, Dr. C. D. Taylor of Pass Christian, who assumed the chair. Dr. James P. Spell of Jackson, chairman of the Reference Committee on Credentials, reported the presence of a quorum of registered and seated delegates in accordance with Section 3, Chapter V, By-Laws of the association.

REPORT OF THE REFERENCE COMMITTEE ON THE SPECIAL SESSION OF THE HOUSE OF DELEGATES

I. The Medical Liability Crisis and Legislative Solutions

Your reference committee considered that report of the Board of Trustees entitled "The Medical Liability Crisis and Legislative Solutions."* After discussion of this report your reference committee recommends the following: (1) That the legislative proposals presented in the report be arranged to indicate our concerns that our first priorities with respect to the malpractice liability crisis are to "clean up our own house" and to provide a system of medical review supported by the medical profession to quickly review and settle just medical claims; and (2) that Legislative Proposal No. 5 be amended to provide that the Board of Trustees in consultation with legal counsel, consider including a provision for mandatory reporting of physician disciplinary actions by hospital medical staffs.

During discussion Dr. J. Elmer Nix of Jackson moved that the reference committee's report be amended to provide in regard to Legislative Proposal No. 3 that the proposed malpractice screening panel have two consumers on it in addition to the three physicians and one attorney. The motion was seconded by Dr. Brantley B. Pace of Monticello and adopted.

The report of the reference committee was then adopted as amended.

II. Physicians' Professional Liability Coverage

Background. In "Supplemental Report E" to the House of Delegates at the 107th Annual Session, May 1975, concerning professional liability insurance, the Board of Trustees and Committee on Professional Liability Insurance noted the decline in the professional liability insurance market and increased cost of coverage. In Mississippi as well as other states, there had been until recently several carriers offering this coverage, now there are no carriers in some states and only one carrier writing new coverage in Mississippi. That one carrier now writes coverage for 1400 Mississippi physicians. There is, in other words, no competitive market for professional liability insurance in Mississippi and no guarantee that the single carrier writing new coverage in Mississippi will continue to do so. Additionally, in spite of a relatively favorable professional liability insurance market, Mississippi has been and will continue to be affected by events on the national professional liability insurance market. In recognition of this, the Board and Committee on Professional Liability Insurance announced plans to study alternatives to the present professional liability insurance market. This study has proceeded and concludes with the information presented in this report.

In considering alternatives to the present professional liability insurance market, the Board and Committee on Professional Liability Insurance have noted that there are some twelve other state medical associations in the process of considering and/or establishing such alternatives and the number increases monthly. We are not alone in our concern over the uncertainty and cost of the current professional liability insurance market. We are ahead of many of these states, however, in that their consideration of alternatives began when there was no pro-

* Editor's Note: The report "The Medical Liability Crisis and Legislative Solutions" as adopted by the House of Delegates was published in a pamphlet and mailed to each MSMA member. Because of this and in the interest of economy, the report is not published in these Transactions.

fessional liability insurance market and a crash program had to be implemented. These crash programs have generally been preceded by a sudden withdrawal of insurance carriers writing professional liability coverage, charges and counter charges between the medical and legal professions and the insurance industry, court challenges of insurance company actions, legislative empass, physicians' strikes and establishment of stop-gap professional liability insurance coverage mechanisms such as joint underwriting associations. North Carolina is a recent example and physicians there are now completely without professional liability insurance while their state medical society hurries to establish a program.

The Board and Committee on Professional Liability Insurance also wish to note that in recognition of the decline of the professional liability insurance market and the interest of state medical societies in this regard, the AMA House of Delegates directed the establishment of an AMA sponsored physician professional liability reinsurance program at its June 1975 meeting. The program's purpose would be to give added backing in coverage capacity and capital to local medical societies establishing programs to write basic professional liability coverage. Such reinsurance is also presently provided by commercial sources.

The Proposal. It is proposed that a nonprofit corporation be formed whose membership would be composed of physicians who are members of the Mississippi State Medical Association; said corporation would be funded and supported by membership dues established by its Board of Directors.

The purpose of the proposed nonprofit corporation would be to provide a professional liability "risk retention and education program." The cost of the program would be underwritten by a pool consisting of payments by members of the pool who would be the recipients of the benefits of professional liability coverage and education. The proposed program would: (1) guarantee protection against the risk of financial loss resulting from malpractice claims; (2) assure availability of professional liability coverage at a reasonable cost; (3) extend professional liability coverage in a realistic amount and under terms which are compatible with the medical profession; and (4) promote the interest of the medical profession and public in assuring adequate provisions of professional liability coverage.

The Present Professional Liability Market. Many factors, all of which will not be discussed here, have resulted in bringing about an unprofitable situation for insurance carriers in the field of professional liability coverage for the medical profession. In order for such coverage to be offered from the standpoint of an insurance carrier, premiums received must be adequate to pay commissions, administrative costs, premium taxes, losses and to show a profit. National carriers report that their expenses in this regard for the past few years have exceeded premium income.

In response to its national market experience, the major carrier writing professional liability coverage in Mississippi announced earlier this year that it would write "claims made" type coverage only. Generally speaking, under "claims made" coverage, only those claims which occur and are reported during the policy period will be covered. The problem of "tail end" coverage or coverage of claims not reported upon retirement, death, disability or change to another professional liability program, if one is available, is handled by the purchase of an endorsement which is priced at the time of purchase.

The "claims made" policy was announced as "an alternative to completely withdrawing from the professional liability insurance market." Additionally, the carrier has stated that "if the claims made policy does not operate to produce a profit, then this plan and perhaps the coverage will be abandoned." The carrier reports it lost several million dollars on this coverage last year.

The Advantages of a Physician Member Nonprofit Corporation Approach to Professional Liability Coverage. The advantages of a physician member nonprofit corporation approach to professional liability coverage tend to justify the conclusion that such an approach would be economically feasible.

In the first place, the history of professional liability insurance coverage of the medical profession in Mississippi indicates that premiums paid have exceeded the amount paid for losses insured against. Insurance companies are first to state that they are not in any line of insurance to lose money. Income will always equal expenses plus a profit and with respect to professional liability coverage, premiums charged physicians will be adjusted accordingly.

If Mississippi physicians should enter into the proposed approach to professional liability insurance coverage, then the experience of the major carrier for professional liability insurance coverage in Mississippi would indicate that contributions to a common pool would be sufficient to discharge any and all demands against the pool incidental to claims which might be processed and honored arising out of the practice of medicine.

The profession would have complete control over the administration of the proposed program to in-

clude complete control over administrative expenses and claims settlement. Present professional liability insurance cost items such as premium taxes, commissions, and profits would not be part of the expenses of the proposed program.

Further, control and education would be asserted with reference to the members who would be participating in the pool. There would be more internal policing and education concerning the practices engaged in by the members, the methods by which claims are received and processed, and the manner in which claims are settled and paid. It is submitted that physician control and education concerning these various aspects of the liability exposure in the practice of medicine would assure greater safeguards with reference to the funds in the pool. The profession would be in command of its future with respect to professional liability coverage.

Based on past experience, it is likewise reasonable to expect that the pool would be solvent and would be maintained at such a level as to adequately insulate each member against the risk inherent in the practice of medicine on an occurrence type basis rather than on the "claims made" type basis now available in the state.

Claims Made vs. Occurrence Policies for Physician Professional Liability Coverage. The occurrence type policy for underwriting professional liability coverage pays for settling claims that "occur" while the policy is in force no matter when the demand is made. The claims made type policy for underwriting professional liability pays for settling claims that are reported (made) during the year the policy is in force.

The major carrier providing professional liability coverage in Mississippi announced earlier this year that it would not write any new or renewal policies for physicians' professional liability coverage except on a "claims made" basis. Concurrently with this announcement, the carrier stated that "excess limits" coverage would no longer be written on new business. This was later withdrawn and the carrier stated that such coverage would continue to be available but at a premium equal to 100 per cent of basic coverage premium instead of the former 30 per cent.

The major carrier insures approximately 48,000 physicians throughout the country and its claims made policy is applicable to all insureds. The claims made policy is intended to counteract the "long tail" in physicians' professional liability claims experience. The "long tail" is the time between the occurrence of the claim, its reporting and settling. The carrier reports that claims experience indicates that it will be five years before most of the claims occurring in 1975 are reported and settled.

In viewing the carrier's reasons for changing to a "claims made" type policy, it is important to remember that the carrier has reacted to its national experience. The carrier states that it "lost" millions of dollars on this line of business and can no longer afford to do this. Therefore, the "claims made" policy was announced as an alternative to completely withdrawing from the market. The carrier *has not "lost"* money on its program in Mississippi.

At this time, the "long tail" which the carrier seeks to avoid with the "claims made" policy is still the carrier's responsibility. With the passage of time, the "long tail" will evolve from the carrier to the physician insured. Upon retirement, disability, death or change to another carrier, the physician insured will have "the option" of purchasing protection against claims incurred but not yet reported. Thus, under the claims made policy, the physician will be "locked-in" to the carrier and at this time the carrier can give no guarantee of what it will cost the physician policyholder to excercise his "option" in the future.

Funding of Proposed Program. Under the proposed program, physician members would be covered on a "claims occurrence" basis. The major carrier's experience in Mississippi with this type policy indicates that this coverage can be successfully provided. Based upon actual losses in Mississippi and even including its projection of "outstanding case losses" and "claims incurred but not reported," the company has had financial success with the occurrence type policy in Mississippi.

Under the proposed program, a pool would be created consisting of funds contributed to it by the members, who would be members of the Mississippi State Medical Association. In order to establish a base amount in the pool, it would be necessary that the members contribute an initial membership fee and the pool would be further improved and maintained by annual contributions in line with the premiums proposed to be charged by the major carrier in the state. The annual contribution would be in the form of an assessment against the members, with a variance in the amount of the assessment based upon the same class distinctions established by the present carrier. Excess limits coverage would be available for all specialties and required for some specialties. Risks of the pool exceeding a certain amount to be established based on the size of the

pool would be reinsured. Contributions to the pool would be tax deductible as a professional expense. Funds in the pool would be invested by the Board of Directors and returns on investments would inure to the benefit of the pool (membership). Nationally recognized actuarial and financial consultation is available and would be obtained on an as needed, "fee for service," basis.

The proposal under which the nonprofit corporation would be formed and the present carrier's loss and underwriting statistics are available as informational addenda to this report and will be presented and discussed in the reference committee hearing following recess of the House.

Summary of Proposal and Reasons for Proposal. There is no competitive market for professional liability insurance coverage in Mississippi and there is no assurance that the major carrier writing such coverage will continue to do so. A nonprofit physician membership corporation is described; said corporation would be chartered for the purpose of providing professional liability coverage to its members and a program of professional and public education concerning physicians' professional liability.

Members of the corporation would pay an initial assessment and annual membership dues based upon the experience of a pool created to provide professional liability coverage and professional and public education in this regard.

The initial assessment and annual dues would provide "occurrence type" professional liability coverage to the members.

The cost experience and projections of premiums by the current carrier give strong indication of the potential success of the proposed program.

The size and experience of the pool in the proposed program would indicate the amount of reinsurance the program should obtain.

The AMA is establishing a corporation to reinsure "captive programs" of state medical associations. Additionally, such insurance is presently provided by other sources.

The "tail" which the present carrier is seeking to avoid with initiation of a "claims made" policy will increasingly evolve to the claims made policyholders with the passage of time.

Recommendation. That this House of Delegates consider and direct the Board of Trustees with respect to proceeding to implement a program of medical liability risk retention and education pursuant to the plan of operation outlined in this report and contingent upon satisfaction of the following conditions and such other conditions as the House may specify:

a. That a nonprofit physician membership corporation be chartered under the laws of the State of Mississippi.

b. That contributions to the corporation by member physicians be tax-exempt to the same extent as their present liability insurance premiums.

c. That reinsurance of the corporation's risks and excess limits coverage be available.

d. That a minimum of 750-1000 physicians express their intent to become members of the corporation through investment of an initial membership fee to provide a pool of approximately $700,000.

Your reference committee feels that the conditions set forth in the Board of Trustees' report upon which the formation of this program is predicated are sufficient guideposts to gauge its acceptance, need and support by the MSMA membership. Your committee feels that the satisfaction of these conditions would be a strong indication by physicians for the need of this program, particularly in view of the fact that development and distribution of a membership prospectus will necessitate only a modest start-up expenditure by MSMA. Your committee feels that this expense would be a worthwhile activity to determine the interest and potential membership in this program. We, therefore, recommend the adoption of this report.

During discussion Dr. Moffitt was requested by the House to specifically state the recommendation and conditions the reference committee was proposing and he did so, referring to the Board of Trustees' Report entitled "Physicians' Professional Liability Coverage."

Dr. Stanley A. Hill of Corinth then moved that the recommendation of the reference committee be deferred pending the MSMA membership being polled to determine support for the proposed nonprofit, physician membership corporation. The motion was seconded by Dr. James R. Cavett, Jr. of Jackson. During discussion of the motion, Dr. Sam A. Johnson of Jackson noted that the reference committee report recommended a minimum of 750 MSMA members joining the proposed corporation and that this was more than a majority of MSMA members and a majority vote. The motion was then put to a vote and lost.

After further discussion, in which it was noted that the proposed corporation would be activated by payment of both the assessment and initial dues, the report of the reference committee was adopted.



The President Speaking

"Influencing Legislation"

JACK A. ATKINSON, M.D.
Brookhaven, Mississippi

JAMES MADISON once said that power must be checked by power. I have been reminded of this dictum on more than one occasion these past few months as I have observed the legislature in action.

Legislative decision making is a ponderous and time consuming process. Most significant issues require the approval of both houses of the legislature, the signature of the Governor, and are subject to judicial review by the courts. These three branches of government must somehow cooperate before anything happens and an idea must be introduced in one house, studied by a committee of that house (after listening to all interested parties), debated on the floor, approved, introduced in the second house, referred to committee, hearings held, debated on the floor, passed, and signed into law by the Governor. By the time all this happens, everyone who can possibly have anything to contribute to the idea under discussion has had an opportunity to do so. The whole system, however, is dependent upon citizen participation in the groups that represent their interest and in the naming of those who make the laws.

There has been considerable involvement by members of the Mississippi State Medical Association during the present legislative session and, hopefully, this interest will be reflected in the passage of legislation supported by organized medicine. This involvement on the part of the medical profession in the political and legislative arena must be continued and intensified if we expect our voice to be heard. More of us must do our homework on legislation and on legislators if we expect to get other than the "ho hum treatment." Our patients and our friends need to know who it is we regard as friend and who it is we regard as foe.

For good or for ill, politicians respond to political pressure created at the grass roots. It was this realization that stirred Madison's comment that only power can check power. ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XVII, NUMBER 4
APRIL 1976

EDITORIALS

Xeromammography

In the past few years, Xeromammography has become increasingly popular as a method of evaluating the breast for carcinoma. Xeroradiology is a process which substitutes a selenium-coated plate for a standard x-ray film. Selenium, a photoconductor, reacts when exposed to an x-ray beam and from this can be reproduced a dry image of the breast.

This method has multiple advantages. It produces less x-ray exposure to the patient. All structures are well visualized, including skin, ducts, calcifications, and vessels. The process is rapid, dry, and is no more costly than conventional mammography. But, most significant of all, it is possible to more accurately interpret the image than with the standard film mammography.

Approximately 25,000 women in the United States die of carcinoma of the breast each year. The instance of carcinoma is diminishing in this country with the exception of two types: carcinoma of the lung and carcinoma of the female breast. Although it has been more than 50 years since Halsted described his procedure of radical surgery for carcinoma of the breast, the extensive efforts of surgeons, researchers, radiotherapists, and pathologists have failed to improve appreciably the absolute 10-year survival of this disease over the past 20 years. The absolute 10-year survival for carcinoma of the breast is 33.4 per cent. When additional selection is made and patients treated without clinically involved axillary nodes, the five-year survival rate free of disease is 74.6 per cent. The performance of a radical mastectomy on patients with carcinoma of the breast before axillary metastases have occurred is still considered the best therapeutic approach in this disease. This early surgery can be accomplished only by earlier diagnosis. The concept that the smaller the lesion when diagnosed and treated the better the chance of cure has still not been disproved.

Most radiologists interpret Xeromammographies in three classes:

Class I. Radiologically benign lesions such as fibroadenomas, cysts, or fibrocystic disease. Biopsy is not indicated. These patients should be observed clinically at regular intervals.

Class II. Equivocal findings on Xeromammography. Suspicious but not definite for malignancy. These patients should have either a biopsy or should be clinically observed and have repeat Xeromammography in three months.

Class III. Highly suspicious of carcinoma. Biopsy is mandatory.

It is the patients in Class II who cause surgeons the most concern. Of these patients biopsied, approximately one out of ten will show malignancy, and yet one hesitates to do ten negative biopsies to find one cancer, although the one patient with cancer should be eternally grateful. Because of the improvement in cure rate from occult carcinoma, it may well be worth biopsying ten breasts for only one positive result. Ninety-five per cent of patients who have lesions detected by mammography alone have no axillary metastasis.

Mammography is probably the most significant recent contribution to the clinical management of breast cancer and permits a less emotional, more reasoned, and more selective approach to management of carcinoma of the breast.

George H. Martin, M.D.
Associate Editor
Vicksburg, MS

PERSONALS

THERESA L. R. BUCKLEY of Biloxi announces the removal of her office to 201 Jackson Street.

ROBERT T. CATES of Jackson served on the attendance committee of the Tulane Alumni Association for the Tulane Educational Meeting.

CARLOS M. CHAVEZ of Jackson announces the opening of his office at Medical Towers Building, 440 E. Woodrow Wilson, Suite 601, for the practice of cardiac-thoracic and vascular surgery.

JOHN ROBERT DAVIS of Corinth was elected to the board of directors of Fidelity Savings and Loan Association.

ALBERT L. DIAZ of Biloxi announces the relocation of his practice of obstetrics and gynecology to the Hospital Plaza on Vancleave Road in Ocean Springs.

JOHN P. ELLIOTT and JAMES TRAPP of Tupelo were guest speakers at the fifth annual educational symposium of the American Association of Medical Assistants, Mississippi Society, held at the Ramada Inn in Tupelo.

ENRIQUE FLECHAS of Natchez announces the opening of his new office for the practice of family medicine at 199 Seargent Prentiss Drive.

ROBERT GRAY has opened his practice of radiology in Batesville in the Physicians' Building at the North Panola Regional Medical Center.

J. L. HENDERSON announces the opening of his practice of orthopedic surgery at 140 Jefferson Davis Blvd. in Natchez.

H. CHAN HENRY has associated with JOHN E. MANN, CHARLES D. GUESS and VICTOR W. YAWN of Jackson in the practice of family medicine at the Southwest Jackson Family Clinic, 5429 Robinson Road.

W. L. JAQUITH of Jackson spoke during opening ceremonies of "Spirit of Service—76" held at the Jackson County Fairgrounds in Pascagoula.

JOSEPH E. JOHNSTON of Mt. Olive has been appointed to the Committee on Cancer of the American Academy of Family Physicians.

BEN E. KITCHENS announces the opening of his office at 302 Kaki Street in Iuka for the practice of general medicine.

KIMBLE LOVE of Vicksburg has been appointed to fill an unexpired term on the city school board.

B. B. MARTIN and S. I. FEURST of Vicksburg announce the relocation of their offices of the Medical Arts Clinic to 1117 Monroe Street.

FRANCIS S. MORRISON of Jackson and UMC attended the Council of Community Blood Centers annual meeting in Scottsdale, Arizona, and was elected chairman of the Membership Committee. Dr. Morrison also attended the annual meeting of the South Central Association of Blood Banks in Houston where he served as program chairman and was re-elected to a three year term as District Director for Mississippi.

NORMAN C. NELSON of Jackson and UMC was a guest speaker at the Mississippi Economic Council's Leadership Mississippi Seminar at the Old Capitol.

LEE ROGERS of Tupelo was guest speaker at the March meeting of the North Mississippi Dietetic Association.

LOUIS A. RUBENSTEIN and WILLIAM B. C. LOBRANO of Ocean Springs announce the association of JAMES B. MARTIN in the practice of family medicine at Spring Plaza Shopping Center.

JACK SENTER of Belmont received a plaque for the service he rendered during the past year as president of the Mid-South Medical Association during 1975.

THOMAS E. STEVENS of Jackson has been elected treasurer of the Mississippi chapter of the Arthritis Foundation. THOMAS E. WILSON, III, is chairman of the medical and scientific committee.

GUY T. VISE, JR., and GEORGE W. WHARTON of Jackson announce the association of JAMES LANGSTON HUGHES, JR., in the practice of orthopedic surgery and rehabilitation at the Mississippi Methodist Rehabilitation Center, 1350 East Woodrow Wilson Drive.

JOE WALKER of Water Valley was presented a Distinguished Service Award for Community Service in Youth Recreation at the Jaycee-Jaycette Mid-Year Awards Program.

VICTOR D. WATSON announces the opening of offices at Mize for the general practice of medicine and surgery.

JAMES S. WILLIFORD of Hattiesburg was inducted as a Fellow of the American Academy of Orthopaedic Surgeons at the annual meeting in New Orleans.

Book Review

Subarachnoid Hemorrhage and Cerebrovascular Spasm. Edited by Robert R. Smith, M.D., and James T. Robertson, M.D. 268 pages with illustrations. Springfield, IL: Charles C Thomas, Publisher, 1975. $26.50.

This book consists of edited papers and taped discussions of a symposium on basic laboratory and clinical research in cerebrovascular spasm.

The book is intended primarily for neurosurgeons who treat patients with cerebrovascular spasm from subarachnoid hemorrhage and for investigators of cerebrovascular dynamics.

The laboratory investigation of subarachnoid hemorrhage is covered in detail. A background of evidence is reviewed dealing with the production of intracranial vascular spasm in the experimental animal.

For the investigator the following subjects will be of special interest:

(a) The experimental model for production of vascular spasm.

(b) The cerebral blood flow in experimental subarachnoid hemorrhage.

(c) The effect of various pharmacological agents on the spastic vessel.

(d) The role of Catecholamines in the production of cerebrovascular spasm.

(e) The innervation of the cerebral blood vessels.

(f) Prostaglandin activity in cerebral vasospasm and the role of prostaglandin in the production of spasm.

The clinician will find the following subjects of particular interest:

(a) The result of a cooperative study of leading universities around the country on intracranial aneurysms and subarachnoid hemorrhage in regard to the problems of cerebrovascular spasm and its modifications with various agents.

(b) Means of prophylaxis used against cerebral vascular spasm.

(c) The use of isoproterenol, lidocaine, phenoxybenzamine and vasodilators in the treatment of vasospasm in man.

There are discussions following each section covering the effectiveness of the various agents considered and the complications related to the use in clinical practice. These discussions are by the leading investigators and clinicians of the field of cerebral vascular spasm.

The book sets forth, in excellent fashion, the magnitude of the problem of cerebrovascular spasm associated with subarachnoid hemorrhage. The difficulty of interpreting studies on experimental animals to the human being is forthrightly discussed. The inconsistencies and variabilities of one patient with subarachnoid hemorrhage to another are well covered. The many unanswered problems of cerebrovascular spasm are discussed, but one is left with the feeling of confidence that the excellent work of the participants of the symposium will produce much progress toward the solution of this most distressing problem of cerebrovascular spasm associated with subarachnoid hemorrhage.

FORREST T. TUTOR, M.D.
Tupelo, MS

NEW MEMBERS

BALL, DAVID ALLEN, Natchez. Born Independence, MO, July 21, 1935; M.D., University of Kansas School of Medicine, Kansas City, MO, 1961; interned St. Lukes, Kansas City, MO, one year; orthopaedic surgery residency, Dickson-Diveley Clinic, Kansas City, MO, 1962-66; elected by Homochitto Valley Medical Society.

FREEMAN, ERWYN E., JR., Jackson. Born Meridian, MS, Jan. 22, 1946; M.D., University of Mississippi School of Medicine, Jackson, MS, 1972; interned, same, one year; pediatric residency, same, 1972-75; elected by Central Medical Society.

JACKSON, JOHN K., Greenville. Born San Antonio, TX, Jan. 29, 1929; M.D., Tulane University School of Medicine, New Orleans, La., 1961; interned Fitzsimmons General Hospital, Denver, CO, one year; anesthesiology residency, University of Colorado

Medical Center, Denver, CO, 1965-67; elected by Delta Medical Society.

McCarthy, Bruce M., Hattiesburg. Born Lowell, MI, July 9, 1943; M.D., Wayne State University School of Medicine, Detroit, MI, 1969; interned Detroit General Hospital, Detroit, MI, one year; orthopaedic surgery residency, Wayne State University School of Medicine, Detroit, MI, 1970-74; elected by South Mississippi Medical Society.

McMillin, F. Lamar, Jr., Vicksburg. Born Little Rock, AR, July 25, 1944; M.D., University of Arkansas School of Medicine, Little Rock, AR, 1971; interned University of Minnesota, Minneapolis, MN, one year; family practice residency, same, 1971-74; elected by West Mississippi Medical Society.

Mitchell, Don Q., Jackson. Born Cleveland, MS, Aug. 11, 1942; M.D., University of Mississippi School of Medicine, Jackson, MS, 1967; interned, same, one year; internal medicine residency, Wilford Hall USAF Medical Center, San Antonio, TX, 1970-72; fellowship in allergy, same, 1972-74; elected by Central Medical Society.

Morgan, M. G., Natchez. Born Shreveport, LA, Mar. 23, 1944; M.D., Louisiana State University School of Medicine, New Orleans, LA, 1970; interned Confederate Memorial Hospital, Shreveport, LA, one year; internal medicine residency, same, 1971-75; also cardiology fellowship; elected by Homochitto Valley Medical Society.

DEATHS

Durfey, John R., Jr., Canton. Born Lexington, MS, June 28, 1925; M.D., University of Alabama School of Medicine, Birmingham, AL, 1952; interned Mississippi Baptist Hospital, Jackson, MS, one year; member of Central Medical Society; died Feb. 11, 1976, age 50.

Pegram, Robert H., Jr., Tupelo. Born Potts Camp, MS, March 21, 1913; M.D., University of Tennessee School of Medicine, Memphis, TN, 1937; interned DePaul Hospital in St. Louis, MO, one year; ob-gyn residency, St. Vincent Hospital, Birmingham, AL, 1938-40; member of Northeast Mississippi Medical Society; died Feb. 21, 1976, age 63.

BRIEF SUMMARY OF
PRESCRIBING INFORMATION
ANTIMINTH® (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017



eliminates Pinworms and Roundworms with a single dose

- **Single dose effectiveness against both pinworms and roundworms**— The only single-dose anthelmintic effective against pinworms *and* roundworms.
- **Nonstaining** — to oral mucosa, stomach contents, stools, clothing or linen.
- **Well tolerated** — the most frequently encountered adverse reactions are related to the gastrointestinal tract.
- **Economical** — a single prescription will treat the whole family.
- **Highly acceptable** — pleasant-tasting caramel flavor.
- **Convenient** — just 1 tsp. for every 50 lbs. of body weight. May be taken without regard to meals or time of day.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Please see prescribing information on facing page. NSN 6505-00-148-6967

Antiminth® ORAL SUSPENSION
(pyrantel pamoate) equivalent to 50mg pyrantel/ml

of the association. Presentations in the scientific exhibit number over 15 this year. We urge every member and guest to view these educational exhibits and the technical exhibits.

Headquarters Hotel—The annual session will be held at the all new Holiday Inn Downtown. The luxurious convention center boasts a whole second floor of 15 meeting rooms, 360 guest rooms, restaurant and lounge. The hotel is located in the heart of Jackson next to the new Deposit Guaranty Plaza. The council is directing an extensive promotional campaign through the JOURNAL MSMA and the Blue Sheet to increase attendance at the annual meeting.

Expression of the Council—Your Council on Scientific Assembly is grateful for the support, cooperation and assistance we have received in planning the 108th Annual Session.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

Council Activities—The council is assigned responsibility for work in the areas of medical education, licensure and facilities for medical education. During this past year the council has continued to emphasize organization and accreditation of instate continuing medical education programs for physicians as authorized by the House of Delegates in 1973. In this connection the council, with the approval of the Board of Trustees, sought and received a grant from the Mississippi Regional Medical Program to conduct a survey of CME programs for physicians in Mississippi leading toward periodic publication of a "Directory of CME Programs for Physicians." The council will present a report on the results of the survey when it is completed.

Preliminary results of the council's CME survey strongly indicate the desire of medical specialty societies, organizations and hospitals to establish CME programs for physicians which will meet accreditation requirements. Such programs are based on identified needs. One of the council's main goals during the 1976-77 association year will be to assist interested medical staffs, specialty societies and organizations in establishing local CME programs that meet accreditation requirements.

Based on mutual interest and cooperation, the council is happy to note its designation as the Continuing Education Committee of the Mississippi Foundation for Medical Care—PSRO during this past year. In its dual role the council believes that it can more effectively respond to requests for CME technical assistance and more effectively coordinate CME activities of joint interest to both MSMA and the MFMC. The medical audit resources and activities of the MFMC-PSRO are prime examples of this process.

In its efforts to encourage CME attendance by physicians and recognition of such attendance, the council will implement a program shortly after this annual session to annually report CME courses attended by members of the association. Under this program, which will be conducted in our MSMA office, members of the association may individually report by telephone or mail their CME attendance and hours. Such members will then annually receive a report on such attendance and hours which may be used to complete application for the "AMA Physician's Recognition Award" and/or CME membership requirements for the American Academy of Family Physicians. Full details of this project will be mailed to members of the association shortly after the annual session.

Accreditation of MSMA Annual Session—Under guidelines of the American Medical Association's Council on Medical Education the council has proceeded to accredit the Council on Scientific Assembly of the Mississippi State Medical Association. Such accreditation will mean that the scientific program of the MSMA annual session may be recognized as meeting Category I requirements for the "AMA Physician's Recognition Award." Initial and periodic accreditation of the Council on Scientific Assembly will be conducted by the Council on Medical Education and this has raised a conflict with respect to action taken at the 107th Annual Session proposing a change in the composition of the Council on Medical Education at this 108th Annual Session. This matter will be discussed in a report to the House but essentially the problem arises from changes making the council on Medical Education elected by the scientific sections of the association. The scientific sections also elect the Council on Scientific Assembly and this means that the association's accreditation body (the Council on Medical Education) would be elected by the same groups which elected the association's scientific programming body (the Council on Scientific Assembly). Under such an arrangement the Council on Medical Education would not be able to accredit the Council on Scientific Assembly because the two are not structured totally separate as required by AMA "Guidelines" for accreditation. The Council on Medical Education would in effect be reviewing and accred-

iting its own scientific program and work.

Council Committees—As part of its accreditation procedure the council seeks volunteers to serve on "CME survey teams." The council would like to especially recognize and express its appreciation to the members of the association who have devoted time to serve on these teams during the past year.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

Two amendments to the MSMA Constitution and By-Laws were presented at the 107th Annual Session. One dealing with the Council on Medical Education changes the composition of the council from three members customarily elected from the north, central and south areas of the state to one member elected from each of the scientific sections. This amendment, if adopted, will be implemented during the scientific section meetings on Tuesday and Wednesday. The amendment reads as follows:

MSMA By-Laws—Chapter IX

"Section 9. Council on Medical Education. The Council on Medical Education shall consist of one member elected from each of the scientific sections for terms of three years each which are so arranged so that no more than three members are elected annually. To this council shall be assigned the responsibilities of encouraging undergraduate and postgraduate study of medicine, licensure, and facilities for medical education in the state. This council shall be responsible to the Board of Trustees."

The other amendment considered at the 107th Annual Session was an amendment to both the MSMA By-Laws and Constitution and as such has laid on the table for final action at the 108th Annual Session. The amendment, if adopted, will realign and reduce from nine to eight the association districts as specified in Chapter VIII, Section 8, MSMA By-Laws. This is one of several redistricting plans that have been before the House of Delegates since the 106th Annual Session. The plans have been presented in response to an expression by the House of Delegates at the 105th Annual Session in 1973 that there should be a more equal ratio of members between districts. Previous redistricting plans before the House of Delegates would have realigned several component medical societies if adopted. The redistricting plan before the House this year does not change any component society boundary. The redistricting plan does reduce the number of association districts from nine to eight and combines association districts 1, 2, 3, 4, and 6 into three new districts. A listing of present incumbents from these districts follows with their terms of office:

Board of Trustees

District 1—Whitman B. Johnson, M.D., Clarksdale (1976)

District 2—James O. Gilmore, M.D., Oxford (1976)

District 3—Robert S. Caldwell, M.D., Tupelo (1976)

District 4—Arthur A. Derrick, M.D., Durant (1977)

District 6—Joe S. Covington, M.D., Meridian (1977)

Under the proposed redistricting plan Drs. Johnson and Derrick are in District 1; Drs. Gilmore and Caldwell are in District 2; and Dr. Covington is in District 3.

Judicial Council

District 1—Gerald A. Smith, M.D., Sumner (1977)

District 2—W. J. Burnett, M.D., Oxford (1977)

District 3—Frank M. Davis, M.D., Corinth (1977)

District 4—William B. Hunt, M.D., Grenada (1978)

District 6—Martin L. Flynt, Jr., M.D., Meridian (1978)

Under the proposed amendment Drs. Smith and Hunt are in District 1; Drs. Lovelace and Davis are in District 2; and Dr. Flynt is in District 3.

Council on Legislation

District 1—James V. Ferguson, Jr., M.D., Greenwood (1977)

District 2—David A. Ball, M.D., Batesville (1977)

District 3—William H. Preston, Jr., M.D., Booneville (1977)

District 4—Ed Pennington, M.D., Ackerman (1976)

District 6—George L. Arrington, Jr., M.D., Meridian (1976)

Under the proposed amendment Drs. Ferguson and Pennington are in District 1; Drs. Ball and Preston are in District 2; and Dr. Arrington is in District 3.

Council on Medical Service

District 1—Donald R. Ellis, M.D., Clarksdale (1978)

District 2—John R. Lovelace, M.D., Batesville (1978)

District 3—Thomas N. Braddock, M.D., West Point (1978)

District 4—Ed Pennington, M.D., Ackerman (1977)

District 6—William M. Gillespie, Jr., M.D., Meridian (1977)

Under the proposed amendment Drs. Ellis and Pennington are in District 1; Dr. Lovelace is in District 2; and Drs. Gillespie and Braddock are in District 3.

The proposed amendment amends Section 8, Chapter VII, MSMA By-Laws to read as follows (changes are in italics):

MSMA By-Laws—Chapter VII

"Section 8. Association Districts. The state of Mississippi shall be subdivided into association districts by counties, provided that all counties in a component society shall be in one association district. These districts are defined as follows:

District 1: *Attala,* Bolivar, *Carroll, Choctaw,* Coahoma, *Grenada, Holmes,* Humphreys, Leflore, *Montgomery,* Quitman, Sunflower, Tallahatchie, Tunica, Washington, *Webster.*

District 2: *Alcorn,* Benton, *Calhoun, Chickasaw,* DeSoto, *Itawamba,* Lafayette, *Lee,* Marshall, *Monroe,* Panola, *Pontotoc, Prentiss,* Tate, Tippah, *Tishomingo, Union,* Yalobusha.

District 3: *Clarke,* Clay, *Kemper, Lauderdale,* Lowndes, *Neshoba, Newton,* Noxubee, Oktibbeha, *Winston.*

Districts 4 and 5: Hinds, Madison, Leake, Rankin, Scott, Simpson, Yazoo.

District 6: *Adams, Amite, Claiborne, Copiah, Franklin, Issaquena, Jefferson, Lawrence, Lincoln, Pike, Sharkey, Walthall, Warren, Wilkinson.*

District 7: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Pearl River, Perry, Smith, Wayne.

District 8: *Hancock, Harrison, Jackson, Stone.*

The following other sections of the MSMA Constitution and By-Laws would be changed by the proposed amendment to indicate the number of new association districts.

MSMA Constitution and By-Laws

Article IX
Chapter VI
Chapter VIII
Chapter IX—Sections 2, 4 and 6
Chapter X—Section 3

REPORT OF THE COUNCIL ON MEDICAL SERVICE

Organization and Duties—The Council on Medical Service is a constitutional body of the House of Delegates consisting of nine members, one from each association district, elected for terms of three years each. The council is charged with the responsibility of ascertaining and studying all aspects of medical care in Mississippi. Under the council's jurisdiction are assigned activities of the association in medical service, emergency service programs, medical care for the indigent and the work of allied medical agencies and organizations. The work of the council and its several committees during the 1975-76 association year are included in this report.

Committee on Nursing—The Committee on Nursing continues to serve as the association's representatives on the MSMA-Mississippi Nurses Association Joint Practice Committee. Primary work before the committee has been study and recommendation concerning the expanded role for the RN approved by the House of Delegates and authorized by statute in 1974. During the year, members of the committee participated in a statewide nursing education conference and attended the meeting of the National Joint Practice Commission. The committee also monitored and attempted to communicate to the State Board of Nurses the medical profession's views and concerns about actions of the board dealing with LPNs.

Committee on Maternal and Child Care—The Committee on Maternal and Child Care continued its study of maternal deaths occurring in Mississippi. A report on the committee's study of maternal deaths occurring in 1972 was published in the December 1975 issue of the JOURNAL MSMA. The committee continues to distribute its "Maternal Health Desk Cards" which serve as a handy reference source of maternity care. Members of the committee are also serving on a new *ad hoc* Committee on High Risk Maternal and Newborn Care whose activities are reported elsewhere by the council.

Committee on Mental Health—Materials on the state's commitment laws as revised by the 1975 legislature were distributed to all MSMA members by the Committee on Mental Health during the past

association year. The council expressed concern last year about the possibility of a non-M.D. director being named to replace the then M.D. director of the Mississippi Department of Mental Health and is happy to note that this did not occur.

Committee on Blood and Blood Banking—This committee of the council has not been active for several years. Based on recent activities and interest in this important medical service area on both the national and local level, the council plans to activate the committee during the 1976-77 association year. The committee will be charged with the responsibility to study and report on all proposed and operational aspects of blood banking and blood service.

JOIN MPAC TODAY

CLASSIFIED

FOR SALE OR LEASE—Doctor's Office Building —vicinity of Memorial Football Stadium and across from University Hospital. Modern clinic built for X-ray and laboratory and 3 or 4 doctors. Nine exam rooms, four offices. 3300 square feet. Ample parking. Contact 969-7720.

FULL-TIME ER PHYSICIAN—for modern, expanding, fully-accredited 467-bed regional medical center with low malpractice ins. rates, salary and fringes negotiable, progressive staff with specialty back up. Excellent schools, college facilities, cultural activities, recreational activities. Contact Dan S. Wilford, Adm., North Mississippi Medical Center, 830 South Gloster St., Tupelo, MS 38801. (601) 842-3632.

NEEDED: One physician to work in an active University Student Health Center beginning July 1, 1976. Please contact J. C. Longest, M.D., Director, Mississippi State University, P. O. Box 5448, Mississippi State, Miss. 39762. Phone: 1-601-325-2431.

Index to Advertisers

Blue Cross and Blue Shield of MS 18
Burroughs Wellcome Co. 10B

Canton Exchange Bank 16
Coca-Cola 15

Dow Pharmaceuticals 106A, 106B, 106C, 106D

For Sale or Lease 19
Fulltime ER Physician 19

Hill Crest Hospital 11
Hyrex-Key Pharmaceuticals 4

Key Pharmaceuticals, Inc. 17

Eli Lilly and Co. front cover

Loma Linda Foods 114B

Mead Johnson Laboratories 8
Miss. State University 19

Pharmaceutical Manufacturers Assoc. 6, 7
Premier Printing Co. 15

Roche Laboratories second cover, 3, 14B, 14C, 14D, third and fourth covers
Roerig and Co. 14A, 124, 125

Smith Kline and French 114A

Warner Chilcott Laboratories 10, 10A
Wayne Medical Laboratories 15

Thomas Yates and Co. 12

IN CONCLUSION

Only about two per cent of the nation's traffic accidents involve pedestrians, yet pedestrians account for more than one-fifth of all fatal accidents, reports the Journal of American Insurance. In urban areas more than a third of all fatal accidents involve pedestrians. In addition, pedestrians suffer at least 120,000 nonfatal injuries a year, the great majority of these in city traffic. For the past 12 years pedestrian deaths have been averaging around 10,000 annually. Those most at risk are the very young and the elderly.

Black children with sickle cell trait -- usually thought to be a clinically benign condition -- weighed less and scored lower on most intellectual tests when compared to normal black children, according to a preliminary data report published in Pediatrics. The study was done in Philadelphia, Pa. Test group and controls were measured in eight different ways for physical development and five different ways for intellectual skills (to test abstract reasoning, vocabulary knowledge, concept skills, conceptual memory and associative learning ability).

A monograph, "Insights on the Child Development Movement in the United States," based on an oral history study supported partly by National Institute of Child Health and Human Development, has been published by the Society for Research in Child Development. It is based on 82 interviews bearing on three themes: major figures of influence during early decades of the field, relations of field of child development to pediatrics and child psychiatry, and relevance of child research to improvement of conditions for children. Monographs are $7 from University of Chicago Press, 5801 Ellis Ave., Chicago, IL.

The Scientific Program Committee for the 42nd annual scientific assembly of the American College of Chest Physicians has announced a call for abstracts. Original investigations in the realms of circulation, respiration, thoracic-cardiovascular surgery and other related systems are invited for presentation at the 1976 annual meeting to be held in Atlanta, Oct. 24-28, 1976. A mandatory requirement is that material submitted will not be published or presented elsewhere prior to Oct. 28. The deadline for submission is May 15.

Vitamin faddism, which is leading more and more people to consume excessive amounts of vitamin A, has reached a point where symptoms of toxicity are becoming apparent, according to Dr. James L. Boyer, a University of Chicago liver specialist. In an article in the New England Journal of Medicine, he described symptoms of two patients who ingested massive doses of vitamin A daily for the last five to eight years. Symptoms include cirrhosis-like damage to the liver, fatigue, fluid accumulation and jaundice. He believes that vitamin A poisoning may be more common than realized.

10-day Bactrim therapy outperforms 10-day ampicillin therapy.



In a multicenter, double-blind study of patients with chronic or frequently recurrent urinary tract infection, Bactrim 10-day therapy outperformed ampicillin 10-day therapy by 27.2%, when comparing patients who maintained clear cultures for eight weeks. Criterion for "clear culture" was 1000 or fewer organisms/ml of urine.

While adverse reactions were mild (*e.g.*, nausea, rash), more serious reactions can occur with these drugs. See manufacturers' product information for complete listing.

Note: Bactrim single strength tablets were used in these clinical trials. However, studies have established the bioequivalency of Bactrim DS with the single strength tablets.

Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

double strength tablets Just 1 tablet B.I.D.

Bactrim™

(80 mg trimethoprim and 400 mg sulfamethoxazole)

2 tablets B.I.D.

For chronic or frequently recurrent cystitis and pyelonephritis due to susceptible organisms.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections evidenced by persistent bacteriuria (symptomatic or asymptomatic), frequently recurrent infections (relapse or reinfection), or infections associated with urinary tract complications, such as obstruction. Primarily for cystitis, pyelonephritis or pyelitis due to susceptible strains of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris* and *Proteus morganii.*

NOTE: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections. The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. **Data are insufficient to recommend use in infants and children under 12.**

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) every 24 hours
Below 15	Use not recommended

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole — bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; fruit-licorice flavored — bottles of 16 oz (1 pint).

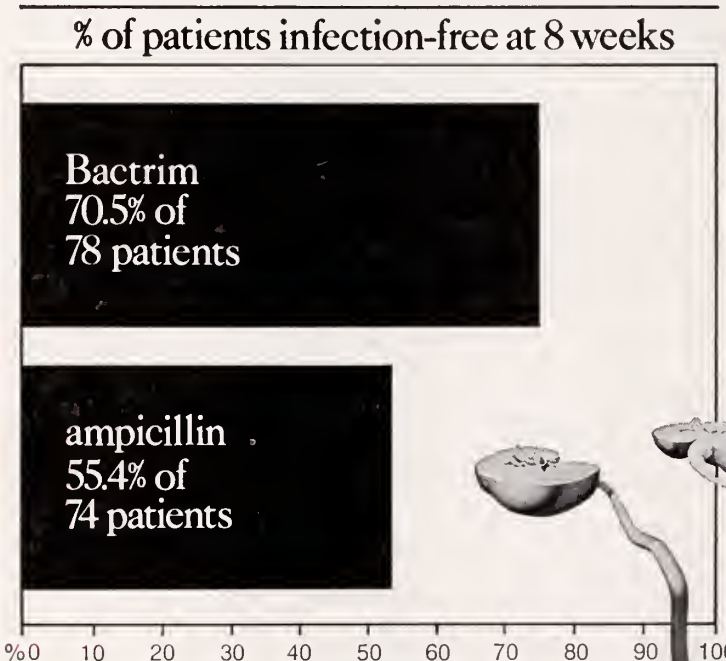
ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

In a multicenter study of patients with chronic or frequently recurrent urinary tract in

Y. ACADEMY OF MED
AST 103RD ST
W YORK N.Y.
10029

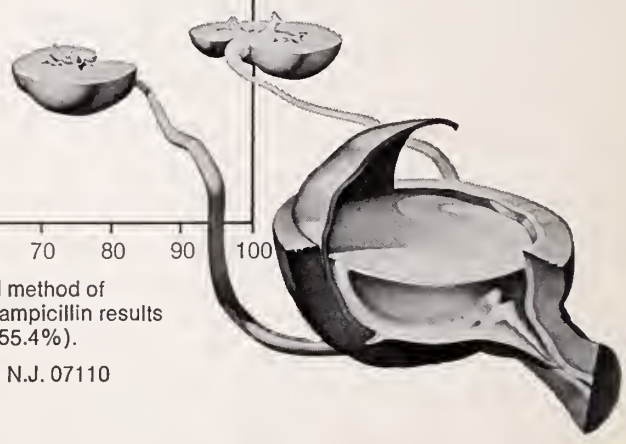
Bactrim™ was 27.2%* more effective than ampicillin keeping patients infection-free for 8 weeks.†



LIBRARY
APR 15 1976
NEW YORK ACADEMY OF MEDICINE

*This percentage is arrived at by the statistical method of dividing the difference between Bactrim and ampicillin results (15.1%) by the percent of ampicillin results (55.4%).

†Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110



Bactrim™ DS
(160 mg trimethoprim and 800 mg sulfamethoxazole)
double strength tablets
Just 1 tablet B.I.D.

Bactrim™
(80 mg trimethoprim and 400 mg sulfamethoxazole)
2 tablets B.I.D.

Please see summary of product information on preceding page.

ROCHE

AMERICAN REVOLUTION BICENTENNIAL 1776-1976

JOURNAL OF THE Mississippi STATE MEDICAL ASSOCIATION

MAY 1976

BALCONY

P. 1976

New from Lilly/Dista Research

NALFON®
fenoprofen calcium

300-mg.* Pulvules®

DISTA
Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

Additional information available to the profession on request.

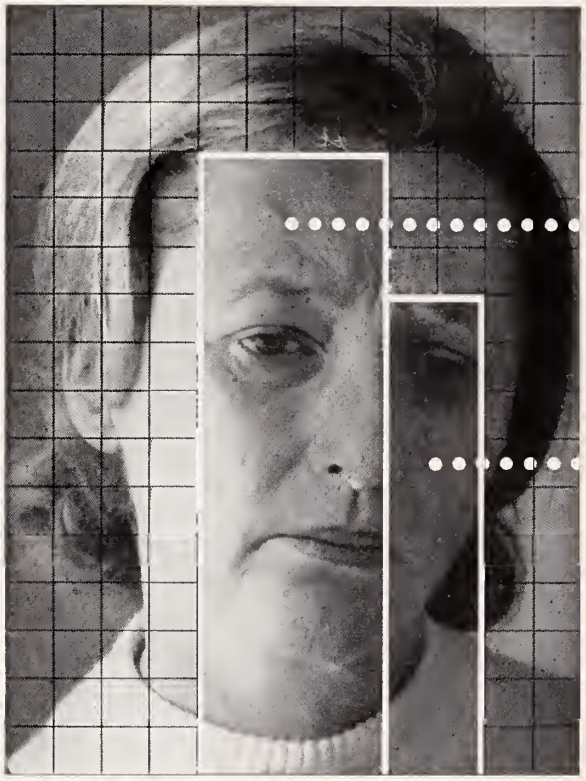
*Present as 345.9 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. fenoprofen.

600091

This Month . . . Severe Dumping Syndromes, Treatment Program for Rheumatoid Arthritis

M.S.M.A.

Both often



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) Ⓒ IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

TO COMPLETE YOUR HEALTH INSURANCE PICTURE, MSMA OFFERS ITS NEW COMPLETE HEALTH INSURANCE PACKAGE:

NEW MAJOR MEDICAL PLAN
Covers 80% of your eligible expenses after you satisfy your deductible amount. Choice of deductibles available. Pays expenses in and out of the hospital!

NEW HOSPITAL MONEY PLAN®
Pays a daily benefit for each day you spend in the hospital because of an accident or illness. Acceptance is GUARANTEED! Pays the benefits directly to *you*!

NEW EXCESS MAJOR MEDICAL PLAN
Picks up where basic insurance programs leave off. Pays 100% of eligible expenses in or out of the hospital—up to $250,000 maximum. And, premiums are LOW! Acceptance is GUARANTEED!

A complete health insurance picture is probably one of the most important items you can provide for your family's financial well-being. To help you combat the rising cost of hospital and medical care, MSMA has entirely revamped its health insurance program to give you the most complete and comprehensive program available . . . and at a low price all can appreciate. Find out more. Mail the coupon below for more information:

THE MSMA INSURANCE PROGRAMS ARE UNDERWRITTEN BY:

CONTINENTAL CASUALTY Co.
ASSOCIATION GROUP DIVISION
Chicago, IL 60685

a division of CNA/insurance

Please send me more details on the NEW MSMA insurance programs:

☐ MSMA MAJOR MEDICAL PLAN ☐ MSMA HOSPITAL MONEY PLAN ☐ MSMA EXCESS MAJOR MEDICAL PLAN

NAME_____

ADDRESS_____

CITY_____

STATE_____ ZIP CODE_____

MAIL TO: Thomas Yates & Co., MSMA Insurance Administrators
P.O. Box 1054, Jackson, Mississippi 39205

Volume XVII
Number 5
May 1976

JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

• EDITOR
W. Moncure Dabney, M.D.
• ASSOCIATE EDITORS
George H. Martin, M.D.
Myron W. Lockey, M.D.
• MANAGING EDITOR
Nola Gibson
• PUBLICATIONS COMMITTEE
Lawrence W. Long, M.D.
Chairman
Frank L. Butler, Jr., M.D.
T. A. Baines, M.D.
and the editors
• THE ASSOCIATION
Jack A. Atkinson, M.D.
President
Lyne S. Gamble, M.D.
President-Elect
James P. Spell, M.D.
Secretary-Treasurer
C. D. Taylor, Jr., M.D.
Speaker
R. Faser Triplett, M.D.
Vice Speaker
Charles L. Mathews
Executive Secretary
H. Cody Harrell
Assistant Executive Secretary
William F. Roberts
Legal Counsel

The Journal of the Mississippi State Medical Association is owned and published monthly by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, $15.00 per annum; $2 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

CONTENTS

ORIGINAL PAPERS

Outline of a Treatment Program for Rheumatoid Arthritis **129** Gene G. Hunder, M.D., Rochester, MN

Problems in Abdominal Surgery III. Severe Dumping Syndromes **132** William O. Barnett, M.D., Jackson, MS

EDITORIAL

Support High Blood Pressure Month **137** Myron W. Lockey, M.D., Jackson, MS

THIS MONTH

The President Speaking **136** "Some Things Do Not Change"

Medical Organization **141** May Is National High Blood Pressure Month

Letter to the Editor **139** Scabies

Copyright 1976, Mississippi State Medical Association



Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P-M-A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

consider the effect on coexisting diabetes when you prescribe a vasodilator*



(POSTERIOR VIEW OF PANCREAS)

no interference in the management of the diabetic patient has been reported with

VASODILAN®
(ISOXSUPRINE HCl)

TABLETS, 20 mg.

the compatible vasodilator

Mead Johnson LABORATORIES

© 1976 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL-54117

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

NEWSLETTER

May 1976

Dear Doctor:

Senator Theo Smith of Corinth used a Mississippi Economic Council meeting in Jackson during April to deliver his views on health matters in Mississippi, the most publicized of which concerned the state's charity hospitals. Senator Smith has been unable to sell his views on the charity hospitals to the Mississippi Legislature. MSMA has been on record for several years to the effect that the state's charity hospitals should either be upgraded or closed.

Mississippi Health Systems Agency, Inc., Governor Finch's choice as the HSA for Mississippi, conducted a series of public meetings throughout the state in April and early May to establish regional councils to advise MHSA on its operation as a Health Systems Agency. The Department of Health, Education and Welfare still has to designate a HSA for Mississippi.

Hospital admissions dropped for the first time in 15 years, according to a periodic survey by the American Hospital Association covering the first nine months of 1975. The number of admissions as of September 30 was 25,145,539, down 0.4 per cent from the comparable period of 1974, reports the American Medical Association's In Brief newsletter.

FTC will investigate Blue Shield to determine "the nature and extent" of physician control and whether such control results in antitrust violations. FTC stressed that the investigation does not mean that violations have occurred. A National Association of Blue Shield Plans spokesman said the group "will respond to and participate in" the investigation and "is confident" that no violations exist.

The Committee on Publications is pleased to announce two new awards received by the Journal MSMA: 1) First Place in the category of publications -- other publications in the 1976 Mississippi Press Women competition and 2) Award of Merit in the best overall four-color magazine category in the 1976 Mississippi Editors and Directors of Information Association competition.

The lowest death rate in history was recorded in 1974, according to the National Center for Health Statistics. The nation had only 9.2 deaths per 1,000 population. In both 1972 and 1973, the rate was 9.4. The average life expectancy for Americans born in 1974 was 71.9 years -- 68.2 years for males and 75.9 years for females. Death rates for suicide and homicide in 1974 were the highest ever recorded.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor



What should a girl, unwed and in need of help do, when she finds herself pregnant?

If you will refer her to us—the Volunteers of America—we will make certain that she is well cared for and her baby is given the opportunity for a healthy, happy life. Our services include full pre-natal, delivery and post-natal care in modern, attractive surroundings—counseling by trained and compassionate professionals and placement of the infant through adoption, if desired.

For a confidential discussion, phone Mrs. O'Brien of the Volunteers of America in New Orleans (504) 891-7713.

Emergency Medicine Symposium Set

The 1976 Indy '500' Symposium will feature postgraduate courses in emergency medicine and medical services on May 12-15 at the Indianapolis Airport Hilton.

The courses are presented by the American College of Emergency Physicians and Emergency Department Nurses Association, Indiana chapters.

For more information, contact Martin Graber, M.D., 3910 Dundee Drive, Indianapolis, IN 46227.

Alcoholics Are Taught Controlled Drinking

Alcoholics can learn to become responsible drinkers, say psychologists at the University Medical Center and the Veterans Administration Hospital in Jackson.

They're teaching their patients "controlled" drinking, the first time the concept has been tried in Mississippi.

"Some alcoholics, especially those who've been heavy drinkers for many years and may have a health problem as a result, need to learn to stop drinking altogether," said Dr. Peter Miller, UMC associate professor of psychiatry (psychology) in the Department of Psychiatry and Human Behavior.

But for the 40 per cent of alcoholics who have little success in abstinence programs, controlled drinking offers an alternative.

"We don't teach social drinking," said Dr. David Foy, director of the VA alcohol treatment program. "Some social drinkers abuse alcohol."

Instead, counselors give patients basic information about alcohol use: how much liquor they can consume in an hour and stay sober; or how to refuse another drink when they know another will be "one too many."

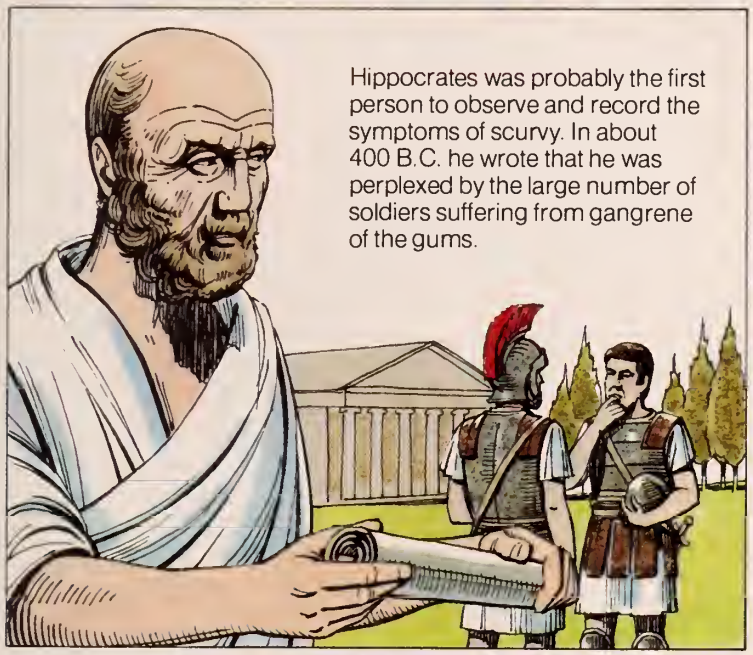
Mississippians in the VA-UMC program master drinking skills in a series of 30-minute sessions with only the counselor and patient participating. Role playing sessions, videotaped so participants can observe their own behavior, help reinforce responses to social pressures they'll meet when they leave the program.

The program also teaches practical ways of coping with pressures and stress without the bottle. Much of the therapy is devoted to marriage and vocational counseling since a drinking problem often disrupts family and job.

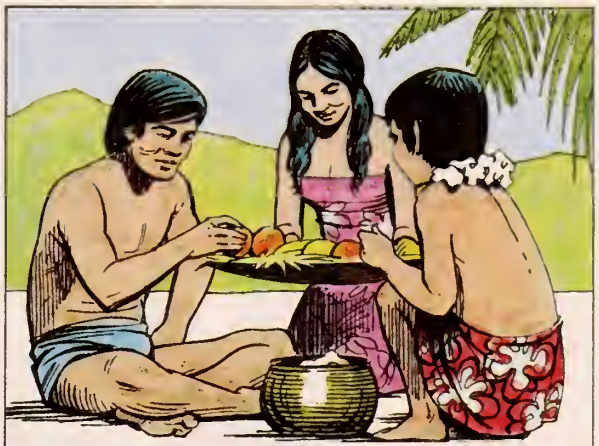
The ALLBEE® with C Scrapbook of Vitamin Facts & Fallacies

Northern and Central Europeans must obtain their vitamin C primarily from cabbage because these countries don't have a Florida or California as a source of citrus fruits. These inhabitants get about twice as much ascorbic acid when they eat their cabbage raw as when they boil it.





Hippocrates was probably the first person to observe and record the symptoms of scurvy. In about 400 B.C. he wrote that he was perplexed by the large number of soldiers suffering from gangrene of the gums.



People in more primitive, less commercialized societies often eat better balanced diets than affluent Americans. These natives instinctively choose nourishing foods because their bodies tell them what they need. The dietary habits of Americans are often influenced by television commercials that appeal to our wants instead of our needs.



Vitamins are so potent that a day's supply weighs only 1/237th of an ounce!



Look for the monogram "AHR" on every Allbee with C capsule. It is your assurance that this is the original and genuine product and not an imitation.

Available on your prescription or recommendation

ALLBEE® with C

High Potency B-Complex and Vitamin C Formula



A.H. Robins Company, Richmond, Va. 23220 A·H·ROBINS



Spasm reactor?

Donnatal®!

	each tablet, capsule or 5 cc. teaspoonful of elixir (23% alcohol)	each Donnatal No. 2	each Extentab
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital (warning may be habit forming)	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.

Brief summary. Adverse Reactions: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Contraindications: Glaucoma; renal or hepatic disease, obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); or hypersensitivity to any of the ingredients

A·H·ROBINS A. H. Robins Company Richmond Virginia 23220

Bicentennial Philadelphia Offers Medical Meetings

Going to Philadelphia this year for the Bicentennial? These medical meetings will be held there during the year:

May 7-10 American Board of Ophthalmology
May 10-16 University Association for Emergency Medical Services
May 23-28 Pediatric-Ophthalmology Seminar
May 24-26 Hahnemann Hospital Symposium on Cardiovascular Disease
July 3-5 American Society of Clinical Hypnosis
Oct. 4-6 Northeastern Tuberculosis and Respiratory Disease Conference
Oct. 11-13 American College of Obstetricians and Gynecologists, District 3
Oct. 21-23 Education Foundation of the American Society of Plastic and Reconstructive Surgeons, Inc.
Oct. 28-30 Group for the Advancement of Psychiatry
Nov. 15-20 National Association for Mental Health
Dec. 1-5 Academy of Ambulatory Foot Surgeons
Dec. 4-7 American Medical Association—Clinical Meeting
Dec. 4-8 American Academy of Orthopedic Surgeons

This list was compiled by the Pennsylvania Medical Society. For more information on any meeting listed above, write the society at 20 Erford Road, Lemoyne, Pa. 17043.

Infant Respiratory Distress Studied

Care of the infant with respiratory distress will be studied May 17-18 at the University of Kentucky Medical Center in Lexington. Registration fee is $35.00.

For further information contact: Frank R. Lemon, M.D., Continuing Education, College of Medicine, University of Kentucky, Lexington, KY 40506.

Is there a tablet containing *only* an expectorant and *only* Glyceryl Guaiacolate? YES!

1. Patient acceptable tablet dose.
2. Single entity expectorant.
3. Measured tablet dose.
4. Sugar-free tablet.

An identifiable white, scored tablet which significantly stimulates the secretion of respiratory tract fluid.

HYTUSS TABS
(GLYCERYL GUAIACOLATE 100mg.)



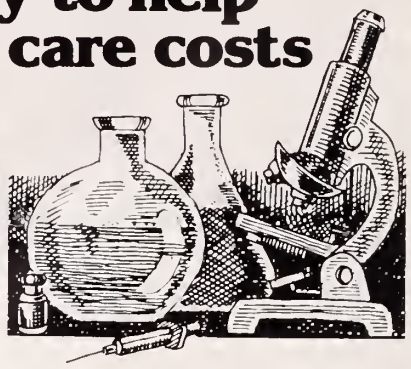


Composition: Each sugar-free compressed tablet contains glyceryl guaiacolate 100mg. **Action and Use:** This preparation utilizes the effective expectorant action of glyceryl guaiacolate which significantly stimulates the secretion of respiratory tract fluid. The increased flow of less viscid fluid favors expectoration and has a demulcent effect on the tracheobronchial mucosa. The primary usefulness of Hytuss Tabs is to promote the change from a dry, unproductive cough to a productive cough. Hytuss is therefore useful in treating coughs due to the common cold, bronchitis, laryngitis, tracheitis, pharyngitis, influenza and the measles. The expectorant action of Hytuss may also provide symptomatic relief in some chronic respiratory disorders when the patient experiences spasms of dry nonproductive coughing. **Precautions:** Extremely large amounts may cause nausea and vomiting. **Administration and Dosage:** *Adults*—1 tablet four times daily. *Children*—6 to 12 years of age; ½ tablet 3 or 4 times daily. HOW SUPPLIED: White, scored, sugar-free, tablet in bottles of 100 - 1,000 - 5,000. **Product Identification Mark:** Hy. **Literature Available:** On request.

Available through all drug wholesalers.

Hyrex
HYREX COMPANY
832 South Cooper
Memphis, Tenn. 38104

Now, a new way to help contain health care costs



$200 OUTPATIENT X-RAY AND LAB COVERAGE

Blue Cross and Blue Shield of Mississippi has made available new optional coverage for its group members—one that should help in the continuing fight to contain the rising costs of health care.

Now, the Plan will pay up to $200 in X-ray and laboratory services per member per year when the services are ordered by a physician and performed in the outpatient department of any participating hospital, or in the physician's office or a clinic.

Hospital space is valuable space, and it is indispensable. But inpatient services must be used only when necessary and the more economical outpatient services utilized whenever possible.

This new coverage is another way Blue Cross and Blue Shield is encouraging the wise and efficient use of health care benefits. Ask your Professional and Provider Relations Representative about the new "$200 outpatient X-ray and lab coverage."

Working together, we can help contain the rising costs of health care.

Blue Cross®
Blue Shield®
of Mississippi

P. O. Box 1043 / 530 E. Woodrow Wilson Ave.
Jackson, Mississippi 39205 / Tel. 982-0010

® Registered Marks Blue Cross Association
® Registered Service Marks of the National Association of Blue Shield Plans

DATELINE

Parents' Smoking Affects Children

Evanston, IL. - A parent's smoking may slow the breathing rate of an unborn child, lower his birthweight, and increase his chances of suffering from bronchitis and pneumonia in the first year of life, the American Academy of Pediatrics' Committee on Environmental Hazards has warned in Pediatrics. The committee said other studies have indicated that, among women who receive suboptimal perinatal care, smoking may increase incidence of fetal wastage.

ACCP Announces New Audiovisual Periodical

Park Ridge, IL. - American College of Chest Physicians and the editorial board of CHEST announce a new dimension in medical education, "Cardiopulmonary Commentary." This new quarterly cassette tape journal is devoted to evaluation and clinical interpretation of selected articles from CHEST. Each tape has 1 hour credit from the AMA Physician's Recognition Award, Category 5-D. For information, write ACCP, 911 Busse Highway, Park Ridge, IL 60068.

Epilepsy Foundation Has Drug Program

Washington, D.C. - The Epilepsy Foundation of America has announced a new nationwide low cost drug program for its members which will reduce the cost of medication by as much as 30 to 70 per cent. The new program is estimated to have a potential saving of as much as $300 to $400 million per year on the cost of anticonvulsant drugs for persons with epilepsy. For information, write Suite 406, 1828 L Street, NW, Washington, D.C. 20036.

Bedtime Story Hour Is Vital to Child

Chicago, IL. - Reading to children contributes significantly to their language development in general and their reading growth in particular, according to an essay in American Journal of Diseases of Children. The author, Joy Moss of the University of Rochester, says if the child can't read, it may be because parents have abdicated the family reading hour in favor of television. She said parents should incorporate a 'story time' into their daily routine.

Ambulatory Care Council Now Does Surveys

Chicago, IL. - The new Accreditation Council for Ambulatory Health Care is accepting applications for surveys. The program is being developed by the Joint Commission on Accreditation of Hospitals, supported in part by a grant from the W. K. Kellogg Foundation. Members include AMA, American Hospital Association, American Group Practice Association. Direct inquiries to ACAHC, JCAH, 875 N. Michigan Avenue, Chicago, IL 60611.

Spring Fling Benefits UMC Lab

Proceeds from the fourth annual University Medical Center benefit gala, Spring Fling, will buy a bacterial detection system for the UMC clinical laboratory.

Dr. Warren Bell, professor of clinical laboratory sciences and chairman of the department, says the new system will speed test results for persons with serious bacterial infections.

Standard methods may take as long as 10 days to grow and identify bacteria in a blood culture. The new technique does it in three.

"It can mean quicker, more accurate treatment for bowel and kidney infections, certain pneumonias, and spinal meningitis," he said.

About 50 laboratories in the United States use the new instrument, developed by a nuclear medicine team at Johns Hopkins University. The system is based on the principle of detection of radioactive gas produced by decomposition of labeled substrates by microbial or biochemical action. The UMC apparatus will be the first of its kind in the state.

The price tag on the bacterial detection system is $4,300, the proceeds goal for Spring Fling.

The UMC Auxiliaries Board sponsored the April 3 event at the Colonial Country Club. Spring Fling is a joint project of the Medical Center Women's Club, University Hospital Auxiliary, Intern and Resident Wives Auxiliary, and Student Wives Auxiliary.

Mrs. Warren Bell, Mrs. Robert Sloan and Mrs. James Suess were overall co-chairmen.

Nephrology Workshop Scheduled This Month

A nephrology workshop will be held May 16, 1976, at the University of Kentucky Medical Center in Lexington. Registration fee is $12.00.

For further information, contact: Frank R. Lemon, M.D., Continuing Education, College of Medicine, University of Kentucky, Lexington, KY 40506.

helping you change things for the better

Canton Exchange Bank

A FULL SERVICE BANK

"Your Account Handled in Strict Confidence"

Each depositor insured to $40,000

Branch Offices

Canton East Branch
Bank Of Madison
Bank Of Ridgeland

FDIC

"Our 95th Year Of Continuous Service"

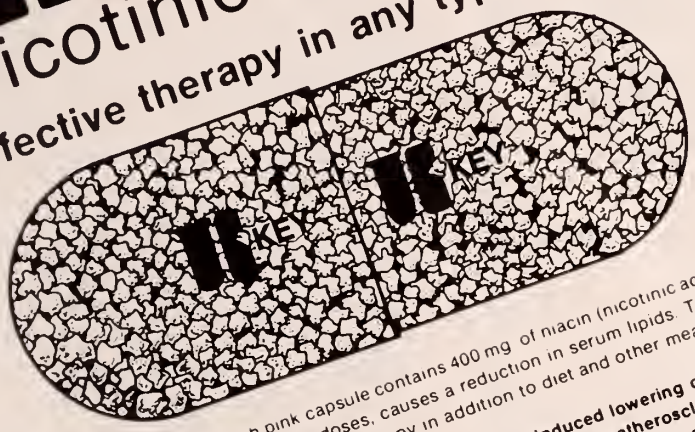
Federal Deposit Insurance Corporation

The Original
Slow Release
Form of Nicotinic Acid

nico-Span®

(nicotinic acid) 400 mg. capsules

Effective therapy in any type of drug responsive hyperlipidemia.



DESCRIPTION: Each pink capsule contains 400 mg. of niacin (nicotinic acid) in a special pelletized formulation for prolonged release.

ACTIONS: Niacin, in large doses, causes a reduction in serum lipids. The exact mechanism of action is unknown

INDICATIONS: As adjunctive therapy in addition to diet and other measures in the treatment of hypercholesterolemia and hyperbetalipoproteinemia.

Notice: It has not been established whether drug-induced lowering of serum cholesterol or other lipid levels has a beneficial or no effect on the morbidity due to atherosclerosis or coronary heart disease. Several years will be required before current investigations can yield an answer to this question.

CONTRAINDICATIONS: Niacin is contraindicated in patients with hepatic dysfunction or in patients with active acute peptic ulcer.

WARNINGS: The use during pregnancy and lactation or in women of childbearing age requires careful weighing of potential benefits versus possible hazards to the mother and child. There are insufficient studies done for usage in children.

PRECAUTIONS: Patients with diabetes, gall bladder disease, past history of jaundice, liver disease, or peptic ulcer should be observed closely. At initial stage of therapy, liver function and blood glucose should be monitored at frequent intervals. Adjustment of diet and/or hypoglycemic therapy may be necessary. Patients undergoing antihypertensive therapy may experience an added vasodilating effect with resulting postural hypotension. Use with caution in patients predisposed to gout.

ADVERSE REACTIONS: Severe flushing, decreased glucose tolerance, activation of peptic ulcer, abnormal liver function tests, jaundice, gastrointestinal disorders, dry skin, pruritus, hyperuricemia, toxic amblyopia, hypotension, transient headache.

DOSAGE AND ADMINISTRATION: The dose and frequency for the administration of NICO-SPAN should be adjusted to the response of the patient. Slow build-up of dosage in gradual increments is recommended to observe efficacy and/or adverse effects. One or two capsules three times a day is the usual dosage. The maximum daily dosage is 6 grams.

Please arrange to provide starter samples and/or complimentary "Starter" prescription booklets for:
nico-Span® (nicotinic acid, 400 mg.)

Samples ☐ "Starter" Rx's ☐

Dr. _____ Specialty _____

Street _____

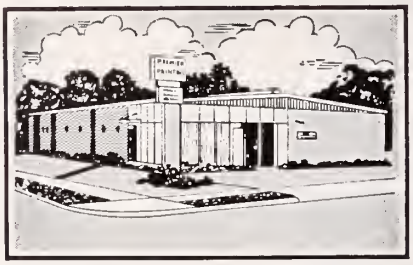
City _____ State _____ Zip _____

Mail to: Key Pharmaceuticals, Inc. 50 N.W. 176th Street, Miami, Florida 33169

KEY PHARMACEUTICALS, INC.
Miami, Florida 33169 (U.S.A.)

PRINTING — OFFICE SUPPLIES

EQUIPMENT — FURNITURE



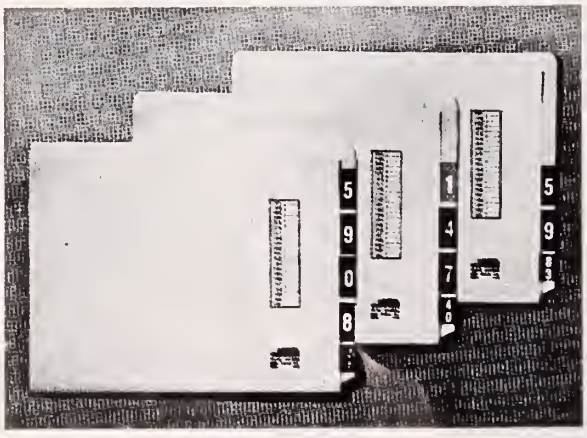
Premier Printing Company

2485 West Capitol Jackson, Mississippi

Phone 352-4091

WHY OUR COLOR CODED FILING SYSTEM?

REDUCES FILING TIME
ELIMINATES MIS-FILES
NO NEED TO REPLACE YOUR PRESENT FOLDERS



PRINTING · OFFICE DESIGN, FURNITURE & SUPPLIES

Mississippi Stationery Company

277 East Pearl Street — Jackson, Mississippi 39201

FOR MORE INFORMATION
CALL COLLECT (601) 354-3436

Swine Virus Is Discussed in Atlanta

Representatives from medical associations met recently at the USPHS Center for Disease Control in Atlanta to be briefed on the new swine-like virus.

According to the CDC report, the virus which causes influenza in man is constantly changing, but most of these changes are minor. The newly identified swine-like virus represents a major change from viruses which are currently circulating in the human population. Since it has the capacity to spread from person-to-person, it could develop into a pandemic strain and cause extensive illness and death.

In February 1976, the new strain, designated A/New Jersey/76, was isolated during an outbreak of respiratory disease among recruits in training at Ft. Dix, NJ. Although an influenza virus of swine has been known as the cause of illness in swine for many years, the Ft. Dix outbreak is the first known example in the United States since about 1930 of person-to-person transmission of a human influenza virus related to that of swine. The influenza virus of swine is relatively stable as opposed to the changing virus which causes flu in people. (There is little difference in the virus which caused flu in swine in the early 1930's from that of today.)

Influenza viruses were first isolated from man in the early 1930's. Officials can only speculate about the characteristics of the viruses prevalent before that time. Testing of blood of individuals who were living in 1918 shows almost all have antibodies to swine-like virus. This suggests that a virus of this sort may have caused the 1918 pandemic. Such antibodies are also found in many persons over the age of 50, suggesting that a swine-like virus was widespread in human populations, perhaps up to 1930. There is, however, no evidence to indicate that the virus recently identified at Ft. Dix has the same characteristics of virulence as the 1918 virus.

The 1918 influenza pandemic was different from other influenza pandemics because of its high mortality and the fact that so many of the fatalities occurred among apparently healthy young men and women. It is estimated that the 1918-19 pandemic resulted in a worldwide death toll of more than 20 million, with half a million of the fatalities in this country. By comparison the Asian flu of 1957—the most severe influenza pandemic since—caused an estimated 70,000 deaths, primarily among the elderly or individuals with chronic illness.

It has been demonstrated that the initial outbreak of swine influenza at Ft. Dix was fairly extensive. Although only 12 cases have been confirmed, extensive blood testing has indicated that several hun-

dred recruits were probably infected during this outbreak. No spread to the nearby civilian New Jersey population has been demonstrated. Hundreds of blood samples of individuals from various sections of the country have been tested. As expected, approximately 80 per cent of people over the age of 50 have swine-like virus antibodies in their blood. Some individuals below the age of 50 also have antibodies to swine virus. However, no additional instances of person-to-person transmission within a community have been demonstrated. In one family, blood tests suggested that person-to-person spread had occurred within that family, but not in the community. On the basis of limited investigation thus far, it would appear that the influenza caused by the swine-like virus is no more virulent than that caused by recently circulating strains of influenza.

As with other strains of influenza, there is no specific treatment but physicians can now significantly blunt the impact of this disease. Vaccines—not available in 1918—are now an effective way to prevent the disease. Antibiotics, also unavailable in 1918, are important in treating the complications of influenza and thus reducing fatalities.

Flu vaccines in the past have been variably effective, depending primarily on how closely they match the strain of influenza. Significant progress has been made in recent years. Today's vaccines are more potent, purer, and produce a higher degree of protection with fewer reactions. It is generally believed that effectiveness ranges somewhere between 70-90 per cent. When a distinctive new strain comes along, scientists are generally able to better match a vaccine to the new strain, and it is likely that a high degree of effectiveness could be achieved in a vaccine against the swine-like virus.

If the decision is made to immunize Americans, the goal would be to immunize the population in a three-month period—September through November 1976. The nation has never attempted an immunization program of such scope and intensity. It would require a major effort by both the public and private sectors, said the CDC officials. Essentially, the plan would rely on the federal government for its purchasing power, technical leadership, and coordination through the Center for Disease Control; on state health agencies for their experience in conducting systematic immunization programs; and on the private health care sector for its extensive medical and other health-related resources. The strategy would be to tailor the approach to the opportunity and need —using mass immunization techniques where appropriate, but also using delivery points already in place, such as physicians' offices, health department clinics, and community health centers.

it's the real thing



70-37

Mississippi Council of Coca-Cola Bottlers

WAYNE MEDICAL LABORATORY, INC.

Providing complete and/or reference laboratory service to hospitals, clinics and physicians.

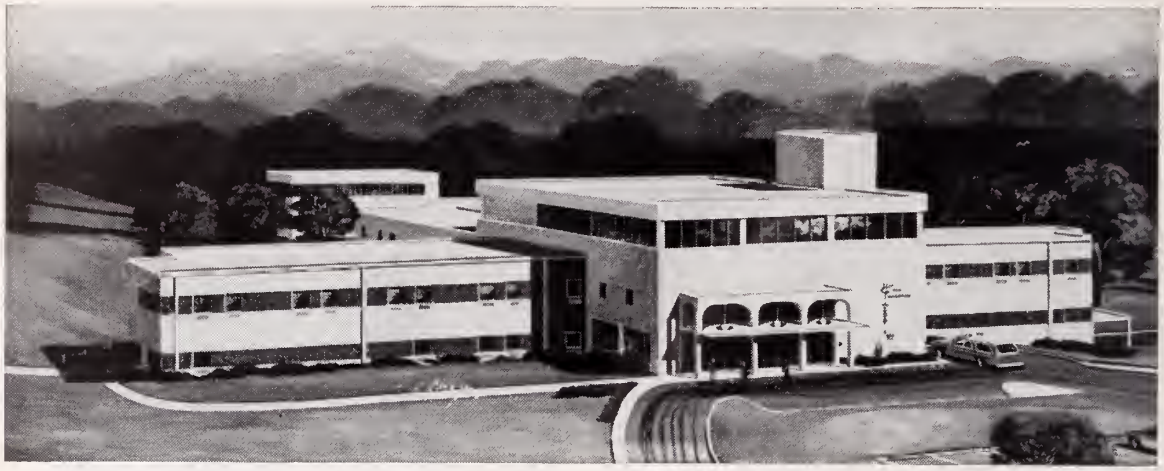
General and specialized tests are offered. Profiles, Thyroid Studies, Pap Smears, Electrophoresis and other Laboratory procedures.

SINCE 1965

Send for fee schedule:

Wayne Medical Lab., Inc.
212 West Seventh St.
Laurel, MS 39440

601-426-2221 TWX—510-960-1993



HILL CREST HOSPITAL

For Intensive Treatment of Psychiatric Disorders

This 101-bed non-governmental psychiatric hospital provides modern facilities for diagnosis and treatment of patients with all degrees of illness, including those who show severely disturbed behavior. Alcoholic and drug abuse patients are also accepted.

In addition to care by psychiatrists and by consultants in all medical specialties, the treatment program includes occupational, recreational, and physical therapy, social services, and tutoring. Emphasis is on short-term, intensive treatment of voluntary patients.

Hill Crest is a member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Alabama Hospital Association, Birmingham Regional Hospital Council.

Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved. Blue Cross Participating Hospital.

ADMINISTRATOR: Robert V. Sanders

HILL CREST HOSPITAL

HILL CREST FOUNDATION, INC.

6869 Fifth Avenue South **Birmingham, Alabama 35212**

PHONE: 205-836-7201

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
May 1976, Vol. XVII, No. 5

ORIGINAL PAPERS

Outline of a Treatment Program for Rheumatoid Arthritis

GENE G. HUNDER, M.D.
Rochester, Minnesota

THE CARE OF THE patient with rheumatoid arthritis is particularly challenging today because there are no curative drugs, and in some patients the ability to alter the course of the disease favorably is limited. However, measures of proven effectiveness in the treatment of rheumatoid arthritis can be prescribed by the primary physician.

In order to use these measures most efficaciously, however, the physician must understand something about the nature of this disease. He must be aware of the fact that rheumatoid arthritis is a systemic disease and frequently involves extra-articular structures as well as the joints. Patients commonly complain of fatigue, may lose weight, and characteristically have morning stiffness of one or two hours' duration or more. The disease tends to be slowly progressive in many patients but the activity fluctuates and the disease can become inactive at any stage. Only a small percentage of patients develop severe crippling. A mild to moderate normochromic or slightly hypochromic anemia that is related to the disease is often present. The degree of anemia and erythrocyte sedimentation rate are coarse measures of the activity of the arthritis. Serum rheumatoid factor is present in 70-80 per cent of patients with rheumatoid arthritis but this factor is not pathognomonic for rheumatoid arthritis and may be absent in early cases. Very high rheumatoid factor titers tend to indicate a poorer prognosis. In recent years, the diagnostic value of synovial fluid analysis has become appreciated. The synovial fluid leukocyte count may vary from a few thousand cells per cubic millimeter to 50,000 or more, depending on the activity of the joint inflammation. Polymorphonuclear leukocytes are the predominate synovial fluid cell.

The author points out that the care of the patient with rheumatoid arthritis is particularly challenging because there are no curative drugs. He discusses the nature of the disease and measures of proven effectiveness in the treatment of rheumatoid arthritis which can be prescribed by the primary physician. It is emphasized that education of the patient regarding the nature of the disease and unhurried visits allowing time for questions to be fully answered will enlist the patient's cooperation and provide the best chances of a successful long-term treatment program.

Synovial fluid complement concentration is usually reduced. These clinical and diagnostic features of rheumatoid arthritis can be reviewed in more detail in the *Primer on the Rheumatic Diseases*, Seventh Edition, which is distributed by The Arthritis Foundation and originally appeared as a supplement to the April 30, 1973, issue of the *JAMA*, Volume 224.

Once a diagnosis of rheumatoid arthritis has been made, the physician must analyze the individual problems of each patient and decide which of the available measures are most appropriate. The pa-

From the Department of Internal Medicine, Mayo Clinic, Rochester, Minn.
Presented before the Section on Medicine, Mississippi State Medical Association, Biloxi, May 7, 1975.

tient needs to understand that the goal of treatment is control of the disease and not its cure. This can be done without creating a pessimistic outlook. The physician should be aware of the concerns and desires of the patient. The patient should be given ample opportunity to discuss any questions he may have. Pamphlets which often help the patient better understand rheumatoid arthritis can be obtained through state chapters of The Arthritis Foundation.

BASIC PROGRAM

All patients are generally started on a basic program of rest, protection of the joints, physical therapy, articular supports as necessary, and aspirin unless intolerant or allergic to it. Ideally, when the arthritis is active, the patient should obtain a total of 10 to 12 hours of rest in bed each 24-hour period. This means eight to ten hours of sleep at night and two to four hours of rest during the day (not necessarily sleeping). Excessive use of joints involved by arthritis is to be avoided because it tends to result in increased joint inflammation. In order to preserve joint motion and muscle strength without excessive stress on involved joints, a physical therapy program of heat, massage and exercise, designed by a physiatrist, is of great importance. Canes, crutches, splints and well-fitted shoes with metatarsal bars and arch supports often help patients continue more normal independent activities. Unfortunately, not all patients are able or even willing to follow these recommendations completely but they should be carried out as closely as possible and the patient should know at what he is to aim.

In low doses, aspirin is an analgesic and at higher doses it has an anti-inflammatory effect of variable potency in different patients. Three tablets (900 mg) of plain, buffered or coated aspirin with each meal and at bedtime (with milk or antacid) can be started and the dose adjusted upwards or downwards depending on the beneficial or adverse effects. In many instances when the maximum safe dose is desired, the aspirin dosage can be adjusted carefully to achieve a blood salicylate level of approximately 20 mg/dl. Long-term aspirin ingestion may result in a minimal chronic gastrointestinal blood loss which can contribute to an iron deficiency anemia. In such circumstances, iron supplements should be given.

In some instances vocational rehabilitation should be considered. Review of available community or social services may be helpful. Discussions of aids provided by local chapters of The Arthritis Foundation are valuable.

SUPPLEMENTAL MEASURES

If the above program has been given a fair trial for two or three months and does not adequately control the patient's arthritis, a supplemental medication may be used. Indomethacin (Indocin) or Ibuprofen (Motrin) can be tried and in some patients these may be more effective than aspirin. Propoxyphene (Darvon) and acetaminophen (Tylenol) could be used also as supplemental medications. Phenylbutazone (Butazolidin) and oxyphenbutazone (Tandearil) might be used occasionally in small doses such as 100 mg once to three times daily alone or in addition to aspirin. The high incidence of toxic effects associated with these latter two drugs preclude larger doses for longer periods of time. Further information about the dosages and precautions in the use of the above drugs and those discussed below can be found in the Second Edition of the *AMA Drug Evaluations*. Other new antirheumatic drugs will probably be available soon. These include fenoprofen (Naflon), tolmatin (Tolectin), naproxen (Naprosyn) and ketoprofen (Orudis).

If the symptoms and findings related to the inflammatory aspects of the disease are still not optimally controlled after several months, a series of gold salt injections or a course of antimalarial drugs might be considered in addition to the basic program. Although the antimalarials such as chloroquine (Aralen) or hydroxychloroquine (Plaquenil) are not potent antirheumatic agents and usually act slowly over several weeks or months, they may be of definite help in some patients in actually suppressing disease activity. Chloroquine, 250 mg/day, or hydroxychloroquine, 200-400 mg/day, can be given daily for several months or longer if helpful. An initial base line ophthalmologic examination and ophthalmoscopy every three to six months will help prevent serious ocular complications. If this medication is found to be helpful, it can be continued but attempts should be made to decrease the dose gradually. If it is not clearly beneficial, it should be discontinued after several months.

Chrysotherapy has become more widely used in recent years for rheumatoid arthritis. Gold salts such as aurothioglucose (Solganal) or gold sodium thiomalate (Myochrysine) appear to be beneficial in a majority of patients with active rheumatoid arthritis and are most effective when given early during the course of the disease. They are given by intramuscular injections, weekly at first, and as the patient improves, every two or three weeks or monthly.

Blood and urine studies should be carried out before each injection, at least initially, and quite frequently thereafter. Under most circumstances gold would be given in preference to antimalarials but when a patient finds that visits to a doctor's office are difficult, antimalarials might be given initially. Gold and antimalarials are not effective in the treatment of symptoms unrelated to the inflammatory processes of rheumatoid arthritis (such as might be related to residual joint damage in patients with inactive disease).

Corticosteroids are very effective in relieving the symptoms of active rheumatoid arthritis. However, these drugs should not be used often for rheumatoid arthritis because the dose frequently must be gradually increased to obtain the same level of symptom suppression and this leads to hypercortisonism. The adverse effects of the drugs may then become more severe and troublesome than the arthritis itself. In some patients with severe joint flare ups, small less hazardous doses such as 1.5 to 3 mg of prednisone (or equivalent) every eight hours, for limited periods of time when added to the basic program, may be very helpful. Because of the problems with side effects, the dose of prednisone should never be high enough to completely relieve the joint symptoms. In patients in whom extra-articular manifestations develop, such as pericarditis, iritis or vasculitis, high doses of oral or parenteral corticosteroids may be necessary. Doses of prednisone (or equivalent), between 20 to 60 mg/day or more, can be used temporarily to control these complications (which are commonly active over a limited time span of only several weeks or a few months).

In a few patients with unremitting disease who appear resistant to corticosteroids or who are controlled only on dangerously high corticosteroid levels, cytotoxic drugs or penicillamine may be indicated. Cyclophosphamide, azathioprine, and related drugs and penicillamine can be effective in controlling the disease but are still considered experimental. Before starting these drugs in a specific patient, consultation with a rheumatologist is preferable.

LOCAL THERAPY

In addition to systemic treatment aimed at controlling the disease generally, measures such as intra-articular injections and surgery for localized symptoms may be very helpful. Injections of a long-acting corticosteroid preparation into one or two joints two or three times a year may make the difference in the overall effectiveness of the patient's program. Strict sterile skin preparation is necessary prior to injections, of course, to avoid septic complications.

Surgical techniques have advanced greatly in recent years and are now of major importance in the overall management of patients with rheumatoid arthritis. Helpful measures include synovectomies to prevent cartilage and bone destruction, plastic procedures to alter or prevent deformity, tendon repairs, and artificial joints. The decision regarding the timing of surgery and the specific procedure depends on careful evaluation by the physician and surgeon.

SUMMARY

Effective treatment for most patients with rheumatoid arthritis can be provided by the interested primary physician. Education of the patient regarding the nature of the disease and unhurried visits allowing the patient to have questions fully answered will enlist the patient's cooperation and provide the best chances of a successful long-term treatment program. Furthermore, a kindly open relationship with the patient will also help prevent the patient from wasting resources in the pursuit of quack remedies which fraudulently promise a cure. Awareness of the contributions of the physiatrist, orthopedist, rheumatologist, and social agencies with appropriate consultations will provide the best total plan for each patient. ★★★

Mayo Clinic (55901)

BICENTENNIAL THOUGHT

"Freedom is the right to choose, the right to create for oneself the alternatives of choice. Without the possibility of choice, and the exercise of choice, a man is not a man but an instrument, a thing."

Thomas Jefferson, 1776

Problems in Abdominal Surgery
III. Severe Dumping Syndromes

WILLIAM O. BARNETT, M.D.
Jackson, Mississippi

THE EARLIEST REFERENCE to the symptom complex which characterizes the dumping syndrome was recorded by Hertz in 1913.[2] The term "dumping" first appeared in a paper by Mix in 1922.[3] There are now two clearly distinguishable varieties of the troublesome problem, the most common of which is referred to as the early postprandial dumping syndrome. The late postprandial dumping syndrome is much less common and is characterized by a distinctive symptom complex.[6]

Early Postprandial Dumping Syndrome. This variety of dumping is probably the most common postprandial complaint following gastric surgery. The incidence varies widely in reported cases, depending considerably upon the diligence with which characteristic symptoms are sought out and also upon the degree of severity of symptoms necessary to achieve the classification of a dumper. The condition may be seen following any operative alteration of the gastric emptying mechanism from the normal function of the pyloris. This includes all types of pyloroplasty, gastroenterostomy and gastric resection. It is probable that symptomatic dumping occurs more often following gastric resection, especially where extensive portions of the stomach are removed, than is seen after vagotomy combined with a drainage procedure. Severe dumping is certainly not confined to the patient with a gastrojejunostomy hookup after resection, having been described many times after the establishment of alimentary tract continuity by gastroduodenostomy. It appears that early dumpers achieve a symptomatic status because of two different pathophysiologic mechanisms. The first relates to the rather immediate passage of large volumes of hypertonic gastric content into the upper jejunum as a result of the loss of normal pyloric valve function which normally retains gastric content within the stomach until a more isotonic state has been achieved. The hypertonic jejunal content draws fluid from the jejunal mucosa which further distends the jejunal lumen resulting in symptoms characteristic of bowel over-distention. Another variety of symptoms results from vasomotor malfunctions in the dumping syndrome. Evidence suggests that this may occur because of abnormal stimulation of the argentaffin cells of the intestinal mucosa which then release excessive loads of serotonin into the circulation (see Figure 1).

This paper is a continuation in the series on problems in abdominal surgery published bimonthly by the JOURNAL MSMA. *The author, professor of surgery at the University Medical Center, discusses the early postprandial dumping syndrome and the late postprandial dumping syndrome, giving diagnosis, treatment and illustrative case reports.*

DIAGNOSIS

Patients with early postprandial dumping syndrome complain of symptoms related to intestinal problems or vasomotor malfunction for reasons mentioned above. The former include hyperperistalsis, epigastric discomfort, bloating, fullness, cramps, nausea, vomiting and diarrhea. True abdominal pain is seldom a prominent part of the symptom complex. Vasomotor symptoms commonly seen are dizziness, weakness, pallor, vertigo, desire to lie down, palpitations, sweating and tachycardia. These occur more frequently than the intestinal symptoms.[1] It is com-

From the Department of Surgery, University of Mississippi Medical Center, Jackson, MS.

mon to learn from these patients that the ingestion of significant quantities of carbohydrate tends to precipitate and exacerbate these symptoms. X-ray examination of the upper gastrointestinal tract usually reveals immediate gastric emptying with rapid filling of the upper small bowel. Gastroscopic examination should be done to rule out other lesions. Other causes of postgastric surgery problems should be differentiated from the dumping syndrome. These include alkaline gastritis, recurrent ulcer, afferent loop syndrome and the small gastric pouch syndrome.

TREATMENT

The great majority of patients with early dumping can be managed nonoperatively. Dietary precautions can do much to lessen discomfort among these patients. Foods which are particularly troublesome include sugars and other carbohydrates. These small molecular substances are particularly offensive since they form hypertonic solutions in the intestine. Best results are obtained by directing the patient to eat meals composed mainly of proteins, fats and large starches. Single large meals should be avoided.

PATHOPHYSIOLOGIC MECHANISMS IN EARLY POSTPRANDIAL DUMPING

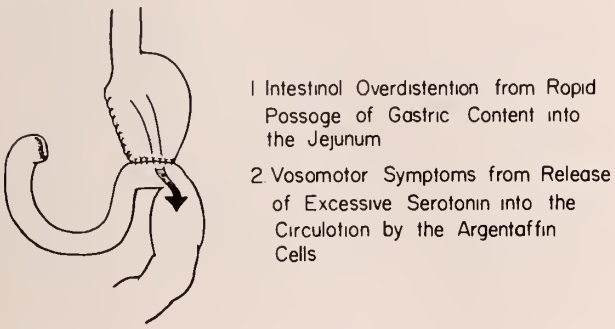


Figure 1. Rapid gastric emptying without achievement of desirable molarity represents the major problem.

The number of meals should be increased to six per day thus allowing smaller caloric intake each time. The gradual achievement of iso-osmolarity in the lumen of the bowel is further aided by minimizing the amount of liquid intake during each meal. It is better to limit the major fluid intake to between meal periods. Many medications have been used in the management of the dumping syndrome. These include antihistamines, sedatives, ganglionic blockers and anticholinergic agents. Also, there is considerable evidence that serotonin antagonists are valuable in the management of this condition.[4]

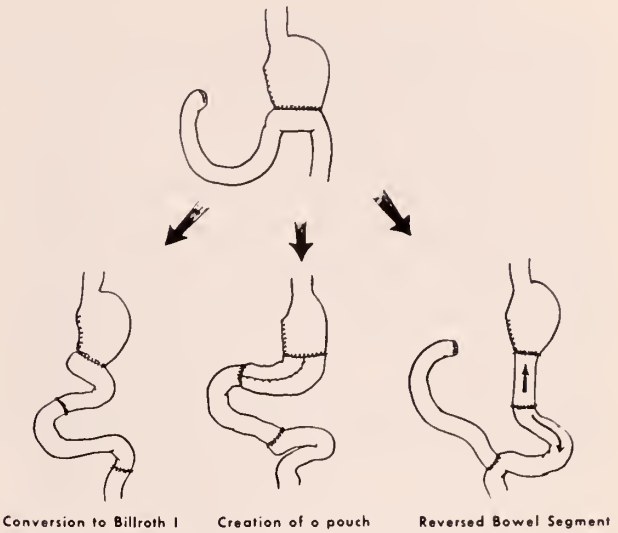


Figure 2. Many procedures have been used for amelioration of dumping symptoms.

For the small minority who cannot be managed successfully by other means, surgical intervention is indicated. Several procedures have been utilized (see Figure 2). Conversion of a Billroth II to a Billroth I arrangement is not attractive to me because of the occasional severe dumping seen in these patients with an initial gastroduodenostomy. Creation of a pouch from lateral anastomosis of jejunal loops has been tried. Our experience has involved the interposition of a reversed loop of bowel next to the stomach. This approach holds promise of success by decreasing the rate of gastric emptying.[5] Such a case is exemplified in the following report. W.F., a 54-year-old female, was hospitalized for upper gastrointestinal bleeding from peptic ulcer disease. Bilateral nephrectomy had been done and she was living as a result of the support of hemodialysis. Medical measures failed to control the hemorrhage and surgical intervention was employed. The procedure consisted of a hemigastrectomy and truncal vagotomy. This resolved the problem of bleeding, but rather severe symptoms of dumping appeared in the early postoperative period. Medical management for the dumping problem was employed for four months at which time examination revealed the patient to be in serious circumstances. The postprandial epigastric discomfort was of such a degree that the patient declined to eat and consequently, weight loss and malnutrition progressed severely. Her physician in charge of medical management was persuaded that remedial gastric surgery was indicated. She was carried to surgery where a 10 cm reversal segment of bowel was in-

terposed between the stomach and the iso-peristaltic small bowel. Amelioration of symptoms has been very satisfactory as evidenced by relief of epigastric discomfort and weight gain.

Late Postprandial Dumping Syndrome. Most patients with postsurgical dumping problems fall into the "early" category; however, a small number, probably less than 10 per cent, manifest a different clinical picture. The late dumping syndrome is apt to appear 2-3 hours after eating (see Table 1). Symptoms are usually of the vasomotor type such as hunger, restlessness, agitation, sweating and tachycardia. Rarely, clouding of the sensorium and convulsive seizures are encountered.[1] The problem has been referred to as reactive hypoglycemia because of the very low level of blood sugar which parallels these symptoms. Early after eating, such patients exhibit a rapid rise in blood sugar to excessively high levels. This is followed by a steep fall in the blood sugar curve to symptomatic levels of hypoglycemia. In contrast to early dumpers, these patients usually do not manifest severe weight loss. Many have found that oral ingestion of sugar relieves the symptoms. Since there are usually no alimentary tract symptoms, there is no hesitancy toward oral ingestion of food. The following case report illustrates such a patient. C.P., male age 46, was admitted to University Medical Center because of dizziness, weakness, tachycardia and occasional syncope. He was no longer able to carry out the duties of his occupation as an automobile mechanic. Recently he had discontinued driving his automobile for fear of an accident resulting from his "blackout" attacks. Previously he had had a Billroth I gastrectomy and vagotomy for duodenal ulcer hemorrhage. His physical appearance was quite good with no evidence of malnutrition or weight loss. A glucose tolerance test revealed a curve which achieved rather high levels in a relatively short period of time. This was followed by a progress decline to 34 mg per cent at 5 hours (see Figure 3). This hypoglycemic level was effective in duplicating the symptoms which had been troubling the patient.

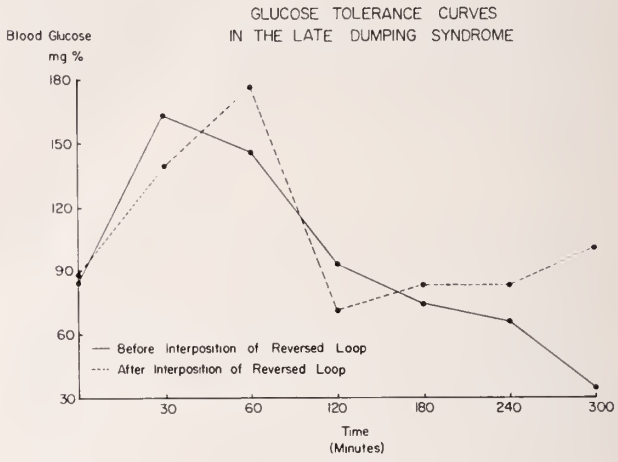


Figure 3. Pre- and postoperative curves in the reported case.

Surgical intervention was employed and the procedure consisted of dismantling the gastroduodenostomy, closure of the duodenal stump, interposition of a reversed, 10 cm loop between the bowel and the stomach and a Roux-en-Y jejunojejunostomy (see Figure 2). Postoperatively there was a moderate degree of gastric retention, but this had cleared by the seventh postoperative day. He currently denies the presence of symptoms which were present preoperatively. Postoperative glucose tolerance tests reveal a curve which leveled off at a considerably higher level than was observed during the preoperative period (see Figure 3). The usual preoperative symptoms failed to occur during this postoperative

TABLE 1

CHARACTERISTICS OF EARLY AND LATE DUMPING SYNDROMES

	Time of Appearance Symptoms	*Possible Pathophysiology Factors*	*Symptoms*	*Weight Loss*
Early	Immediately after eating	Intestinal distention Serotonin activity	Epigastric discomfort Bloating Dizziness Palpitations Tachycardia	Significant
Late	2-3 hours after eating	Hypoglycemia	Sweating Weakness Dizziness Syncope	Not usually a problem

glucose tolerance test. His weight is now above the preoperative level and he is gainfully employed.

SUMMARY

The dumping syndrome is among the most common of postgastric surgical problems. It is helpful to distinguish between the early and late varieties of this syndrome in order to accurately evaluate symptoms and plan therapy. The former is much more common and is characterized by alimentary tract and vasomotor symptoms. The latter occurs 2-3 hours after meals and is usually productive of only vasomotor symptoms. Diet and medications are successful in controlling symptoms of the great majority of these patients; however, surgical intervention is usually rewarded by significant improvement in the small, but significant minority where other measures have failed. ★★★

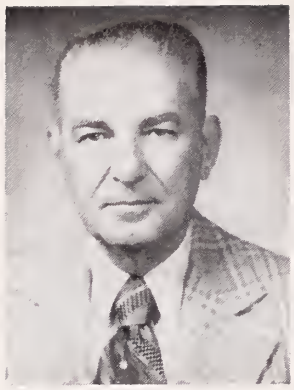
2500 North State Street (39216)

REFERENCES

1. Herrington, J. L., Jr.: Remedial Operations for Postgastrectomy Syndromes. Curr. Probl. Surg. April, 1970, pp. 40-41.
2. Hertz, A. F.: Causes and Treatment of Certain Unfavorable After Effects of Gastroenterostomy. Am. Surg. 58:466, 1913.
3. Mix, C. W.: "Dumping Stomach" Following Gastrojejunostomy. S. Clin. North America 2:617, 1922.
4. Peskin, G. W. and Miller, L. D.: The Use of Serotonin Antagonist in Postgastrectomy Syndromes. Am. J. Surg. 109:7, 1965.
5. Sawyers, J. L. and Herrington, J. L., Jr.: Superiority of Antiperstaltic Jejunal Segments in Management of Severe Dumping Syndrome. Ann. Surg. 178:311, 1973.
6. Woodward, E. R.: The Postgastrectomy Syndromes. Springfield, Charles C Thomas, 1963.

YOU'RE INVITED

America's Bicentennial—You're Invited is the title of the brochure prepared by the Atlanta Regional Office of the National Bicentennial Administration. Listed in the brochure are major Bicentennial events taking place in the Southeastern United States. It is an invaluable aid for persons planning to travel during 1976. For your free copy, write the Bicentennial Commission, P. O. Box 571, Jackson, MS 39205.



The President Speaking

"Some Things Do Not Change"

JACK A. ATKINSON, M.D.
Brookhaven, Mississippi

IN THIS, MY last president's page, I want to thank all of those who have made this year a rewarding experience: my fellow physicians who have shared their concerns with me and encouraged me in my efforts to articulate those concerns before the public and state government; to the staff of the Mississippi State Medical Association who have gone about their usual excellent job in running the affairs of the organization; and to my wife whose understanding and patience has, as always, been a source of strength and encouragement.

I come to the conclusion of this year with mixed emotions—relief that the duties of this office now pass on to my successor, gratitude to those who have heard us out, some satisfaction that our proposals fared better in the legislature than I at one time thought they might, but most of all I feel a growing conviction that some of the fundamental principles for which we have stood ought not to be compromised. Today the name of the game is compromise and the proper stance, I am told, for all wholesome minds is toward the future, not the past. Yet in an era of rapid change all of us might do well to sort through the principles and institutions of our society and our profession and those judged to be demeaning and unjust we should alter, but those among them judged to be sound and of good report we should preserve. Surely there is such a thing as relevance—the determined effort of science to meet the contemporary needs of our society, but just as surely there are such things as principle, integrity and pride (personal and professional). Some things do not change. For example, the sanctity of the physician/patient relationship should not be compromised. It is a relationship that cannot be captured in a creed nor can it be reduced to words. It cannot even be identified with a code of conduct or bound by a set of rules. The trust factor between doctor and patient is part and parcel of the art of medicine and must be preserved. We need to preserve such institutions and ideals as individual initiative and personal responsibility, the passion for learning, the dedication to service. These are some of the fabric from which medicine is made and which has held medicine together down through the years. People whose only moral base is service of self ought not to complain about being lonely. Nations and individuals committed entirely to material pursuits can expect their foundations to shake when the laws of economics no longer work in their favor.

Centuries ago St. Augustine contemplated the fall of the Roman Empire. How could it have happened, he wondered. Here was Rome, the center of learning, art and education, being destroyed

(Continued on page 137)

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, June 26-July 1, Dallas. Clinical Convention, Dec. 4-8, 1976, Philadelphia. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

La.-Miss. O. and O. Society, April 28-May 1, 1977, Point Clear, Ala. Arthur Hays, M.D., Secy., 3017 13th St., Gulfport 39501.

STATE AND LOCAL

Mississippi Academy of Family Physicians, Annual Meeting, July 7-10, 1976, and July 6-9, 1977, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 109th Annual Session, May 2-5, 1977, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Smith, Yazoo.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Gerald A. Smith, Secy., P.O. Box 128, Sumner 38957. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. A. K. Martinolich, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Reginald P. White, Secy., East Mississippi State Hospital, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, April, June, August, October, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., Jefferson Davis Memorial Hospital, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. D. Stanley Hartness, Jr., Secy., 314 Adams St., Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Lee H. Rogers, Secy., 610 Brunson Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, October. Cherie Friedman, Secy., 1004 Jackson Ave., Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. James H. Sams, Secy., P.O. Box 1381, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, May, July, September, November. Dewey Laner, Secy., Doctors Plaza, Suite 206, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. John L. Smith, Secy., No. 1 Medical Blvd., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

When the same patient makes your office a merry-go-round of somatic complaints



Adapin® (doxepin HCl) may be what she needs

I'm so jumpy, I'm afraid of my own shadow.

I have these headaches almost everyday—I can't understand it, I never used to have them.

Doctor, is it right that I should be so constipated all the time?



Anxiety/depression could be the basis of her somatic complaints
You know the type. She's got a new symptom every visit. And there's never any physiological basis. When you see the chronic "complainer," a diagnosis of depression may be considered... and an Rx for Adapin.

Adapin allays anxiety; improves sleep; brightens the outlook
Adapin can often help the chronic "complainers" get positively reinvolved with life. Adapin almost immediately allays symptoms of anxiety and tension. And from the earliest days it makes it easier for the patient to get to sleep—helps her stay asleep longer. And where there is underlying depression, Adapin usually begins to lift it within three or four weeks.

Please see following page for prescribing information

ADAPIN®
(Doxepin HCl)
Capsules, 10 mg, 25 mg and 50 mg

PENNWALT

ADAPIN®
(Doxepin HCl)



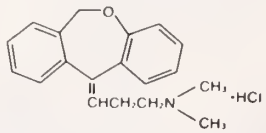
10 mg. **25 mg.** **50 mg.**

Usual optimum dosage is 75 to 150 mg. per day.

Prescribing information:

DESCRIPTION

Adapin (doxepin HCl) is an isomeric mixture of N, N-dimethyl-dibenz(b,e) oxepin- $\Delta^{11(6H)}$, γ propylamine hydrochloride.



ACTIONS

Adapin has a variety of pharmacological actions with its predominant action on the central nervous system. While its mechanism of action is not known, studies have demonstrated that it is neither a monoamine oxidase inhibitor nor a primary stimulant of the central nervous system.

INDICATIONS

In controlled clinical evaluations, **Adapin** has shown marked antianxiety and significant antidepressant effects. **Adapin** has been found to be well tolerated even in elderly patients.

Adapin is indicated for the treatment of patients with:

1. Psychoneurotic anxiety and/or depressive reactions.
2. Mixed symptoms of anxiety and depression.
3. Anxiety and/or depression associated with alcoholism.
4. Anxiety associated with organic disease.
5. Psychotic depressive disorders including involutional depression and manic-depressive reactions.

Target symptoms of psychoneurosis that respond particularly well to **Adapin** include: anxiety, tension, depression, somatic symptoms and concerns insomnia, guilt, lack of energy, fear, apprehension and worry.

Because **Adapin** provides antidepressant as well as antianxiety effects, it is of particular value in patients in whom anxiety masks depression. Patients who have not responded to other antianxiety or antidepressant drugs may benefit from **Adapin.**

In a large series of patients systematically observed for withdrawal symptoms, none were reported—a finding which is consistent with the virtual absence of euphoria as a side effect and the lack of addictive potential characteristic of this type of chemical compound.

CONTRAINDICATIONS

Because **Adapin** has an anticholinergic effect, it is contraindicated in patients with glaucoma or a tendency toward urinary retention.

Use of **Adapin** is contraindicated in patients who have been found hypersensitive to it.

WARNINGS

Usage in Pregnancy—Adapin has not been evaluated in pregnant patients. Therefore, it should not be used during pregnancy unless, in the judgment of the physician, it is essential to the welfare of the patient.

In animal reproduction studies of **Adapin,** gross and microscopic examination of the offspring gave no evidence of drug-related teratogenic effect. Following doses of up to 25 mg./kg./day for 8 to 9 months, no changes were observed in the number of live births, litter size, or lactation. A decreased rate of conception was observed when male rats were given 25 mg./kg./day for prolonged periods—an effect which has occurred with other psychotropic drugs and has been attributed to drug effect on the central and/or autonomic nervous systems.

Usage in Children—The use of **Adapin** in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors—Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with **Adapin.** The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

PRECAUTIONS

Drowsiness may occur with **Adapin (doxepin HCl);** therefore, patients should be warned of its possible occurrence and cautioned against driving a motor vehicle or operating hazardous machinery while taking the drug.

Patients should also be cautioned that the effects of alcoholic beverages may be increased.

Since suicide is an inherent risk in depressed patients and remains a risk through the initial phases of improvement, depressed patients should be closely supervised.

Although **Adapin** has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Compounds structurally related to **Adapin** can block the effects of guanethidine and similarly acting compounds. However, at the usual clinical dosages, 75 mg. to 150 mg. per day, **Adapin** has been given concomitantly with guanethidine without blocking its antihypertensive effect. But at dosages of 300 mg. per day or higher, **Adapin** has exerted a significant blocking effect.

Adapin, like other structurally related psychotropic drugs, potentiates norepinephrine response in animals. But this effect has not been observed with **Adapin** in humans, which is in accord with the low incidence of tachycardia reported clinically.

ADVERSE REACTIONS

Anticholinergic Effects: Dry mouth, blurred vision and constipation have been reported. These are usually mild, and often subside as therapy is continued or dosage reduced.

Central Nervous System Effects: Drowsiness has been observed. It usually occurs early in the course of therapy and tends to subside as therapy continues. (See Dosage and Administration section.)

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported adverse effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects (such as increased sweating), weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

DOSAGE AND ADMINISTRATION

In most patients with mild to moderate anxiety and/or depression: 10 mg. to 25 mg. t.i.d. to start. A starting dosage of 10 mg. t.i.d. for a period of four days may reduce the initial drowsiness experienced by some patients, and may be tried in cases where drowsiness is clinically undesirable. Decrease or increase the dosage at appropriate intervals according to individual response. Usual optimum dosage is 75 mg. to 150 mg. per day.

In some patients with mild symptomatology or emotional symptoms accompanying organic disease, dosage as low as 25 mg. to 50 mg. per day has provided effective control.

In more severe anxiety and/or depression: 50 mg. t.i.d. may be required to start—if necessary, gradually increase to 300 mg. per day. Additional effectiveness is rarely obtained by exceeding 300 mg. per day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

OVERDOSAGE

Symptoms—An increase of any of the reported adverse reactions, primarily excessive sedation and anticholinergic effects such as blurred vision and dry mouth. Other effects may be: pronounced tachycardia, hypotension and extrapyramidal symptoms.

Treatment—Essentially symptomatic; supportive therapy in the case of hypotension and excessive sedation.

HOW SUPPLIED

Each capsule contains doxepin, as the hydrochloride: 10 mg. (NDC 0018-0356), 25 mg. (NDC 0018-0357) and 50 mg. (NDC 0018-0358) capsules in bottles of 100, and 1000.

Brighter days ahead for your psychosomatic complainers



PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XVII, NUMBER 5
MAY 1976

EDITORIALS

Support High Blood Pressure Month

For the second year in succession, the month of May has been designated as National High Blood Pressure month. Some 150 national organizations have joined in this effort to inform the public as to the need for continued, periodic check-ups, preventive measures and appropriate management of hypertension. Through this cooperative effort it is hoped that a gradual reduction in the prevalence of hypertension and the complications associated with this disease can be accomplished.

Fundamental to the control of any disease state is a heightened awareness of the problem by both the professional and lay public. In this cooperative effort the public media will be used to convey general information about the disease, how to detect it, and what can be done about it. Many professional, labor, social, and business groups will participate by asking all of their members and/or employees to commit themselves to practice personal preventive medicine by doing the following: obtain blood pressure check-ups for themselves and their family members during the month of May, and once or twice yearly thereafter; if found hypertensive, seek medical help; and take an active role in treatment and control.

Mississippi physicians may participate in this program on a personal and professional basis. Personally they should commit themselves to the above objectives and follow through with this commitment. Professional participation could be in any one or all of the following areas. Education of the lay public cannot be fully accomplished by the public media and physicians must participate by responding to inquiries by individuals and by making group presentations on this problem. Medically, each physician should entertain a commitment to screen all patients for hypertensive disease. Mississippi physicians may further commit themselves to the control of hypertension by actively pursuing continuing education in the management of this problem and its complications and in turn actively applying these principles to management of specific patients.

MYRON W. LOCKEY, M.D.
Associate Editor
Jackson, MS

The President Speaking

(Continued from page 136)

by a bunch of barbarian wild men dressed in animal skins with no art or culture to speak of. How could it be? Augustine begins his analysis with a question. What, he asks, marks a nation or a state or an institution? And he answers, each of these is an assemblage of people bound together by the object of their common love. Then he asks, what did Rome love? And he answers, Rome loved glory and Rome achieved glory. Now, reasons Augustine, it is no one's fault but Rome's that glory is a passing ephemeral value, here today, gone tomorrow. Ah! says Augustine, if Rome had intended to be eternal it should have built on values that are eternal like justice, truth, and the sanctity of human life. Some things just do not change. ★★★

NEW MEMBERS

OLIVO, MARCIANO T., Oxford. Born Philippines, Sept. 11, 1930; M.D., University of Santo Tomas, Manila, Philippines, 1955; interned, same, one year; anesthesiology residency, Mercy Hospital, Pittsburgh, PA, 1957-59; anesthesiology residency, Mainsonneuva Hospital, Montreal, Canada, 1959-60; elected by North Mississippi Medical Society.

PENDERGRASS, JOHN L., Hattiesburg. Born Clarksdale, MS, Nov. 12, 1944; M.D., University of Mississippi School of Medicine, Jackson, MS, 1969; interned Baylor Medical Center, Dallas, TX, one year; ophthalmology residency, Parkland Memorial Hospital, Dallas, TX, 1970-73; elected by South Mississippi Medical Society.

WELCH, PAUL B., Jackson. Born Laurel, MS, June 12, 1945; M.D., University of Mississippi School of Medicine, Jackson, MS, 1972; interned and pediatric residency, University Medical Center, Jackson, MS, 1972-75; elected by Central Medical Society.

Medico-Legal Briefs

$275,000 FOR ALLEGED NEGLIGENCE DURING HYSTERECTOMY

Due to alleged negligence in performance of a hysterectomy, during which an unidentified mass was discovered, a patient required 12 additional operations. In a suit for malpractice, the patient was awarded $225,000 and her husband $50,000 by a California jury.

The patient, 47 years old, was to undergo a routine hysterectomy and an anteroposterior repair after an extensive workup. During the operation, the surgeon discovered a mass.

A general surgeon, who was walking in a nearby hospital corridor, was called in for consultation. The consultant later said that he had taken a quick look, indicated that he did not know what it was, and advised a biopsy if there was concern about cancer. He said that he was in the room no more than two minutes.

The operating surgeon and the assistant surgeon said that the consultant was in the operating room for 5 to 15 minutes. They said that he was told about the patient's history and that he reviewed x-rays, concluding that a hysterectomy could be safely completed without performing a colostomy.

All parties agreed that the consultant did not touch the mass because he was not scrubbed. The surgeon said that the consultant was asked to scrub if he thought it necessary.

The patient and her husband sued the surgeon, the assistant surgeon, and the consultant. They contended that the subsequent operations were necessary to remove pockets of infection that allegedly occurred because of failure to perform a colostomy at the time of the hysterectomy. The patient had residuals including loss of sexual feeling, a badly scarred abdomen, and mesh embedded in her abdominal wall. She was required to wear abdominal supports and claimed to be "emotionally broken."

Experts testifying for the patient contended that, because of the nature of the mass, a colostomy should have been performed and that use of oral laxatives, enemas, and rectal tubes was contraindicated during the postoperative period. They said that any physician performing pelvic surgery should have been able to recognize the nature and significance of the mass.

The consultant said that he did not participate in the case to the extent of a professional consultation, pointing out that he did not touch the mass. He felt that reliance on his opinion by the surgeon and the assistant would be below the standard of care.

The surgeon and the assistant said that their acts were within the standard of care, including their reliance on the consultant's opinion. They also contended that the patient had diverticulitis and that a colostomy was not necessary at the time of the first operation. The surgeon said that the assistant participated in the patient's postoperative care.

The verdict was against the surgeon and the assistant surgeon only.—*Jines v. Abarbanel* (Cal. Super.Ct., Los Angeles Co., Docket No. WEC 28038, Oct. 28, 1975)

PERSONALS

FRANCIS JEWELL BAIRD of Columbus served as 1976 King of the Columbus pilgrimage during the Junior Auxiliary Pilgrimage Pageant Ball.

THOMAS H. BLAKE, JR., has associated with ERNEST J. HOLDER, JAMES C. BASS, JR., and CLEVE E. JOHNSON of Laurel for the practice of orthopedic surgery at the Laurel Bone and Joint Clinic, 424 South 13th Avenue.

ROBERT L. BUCKLEY of Columbus has been appointed infirmary physician at Mississippi University for Women. Dr. Buckley also practices private pediatrics in Columbus.

S. R. EVANS, JR., of Greenwood recently attended a two-day educational program, "Progress in Ob-Gyn 1976," at the University of Alabama School of Medicine.

RICHARD FULLER of Jackson will set up his practice of internal medicine in Brookhaven in early summer. He is building a medical clinic across from King's Daughters Hospital.

THOMAS GANDY of Natchez has been elected chairman of the board of trustees of Jefferson Davis Memorial Hospital.

M. E. HINMAN of Vicksburg is serving as president of the Community Concert Association.

WENDELL HOLMES of McComb was named king of the 1976 Heritage Ball held at the National Guard Armory in McComb.

DANIEL T. KEEL, JR., of Brookhaven, JOHN W. EVANS and WILLIAM M. FLOWERS, JR., of Jackson have been named fellows of the American College of Radiology.

ROBERT ASHFORD LITTLE of Gulfport has been elected chief of staff of Garden Park Community Hospital in Gulfport. Dr. Little is in the practice of ophthalmology.

BERNARD S. PATRICK of Jackson and UMC attended the 29th annual symposium on Fundamental Cancer Research and spoke on "Neurosurgical Management of Intractable Pain" at the A.M.T.A. meeting in Houston during March.

ERNEST D. REYNOLDS of Clinton was honored by the Clinton Sertoma Club for his longtime service to Clinton and to Northwestern Hinds County. He received the 1975-76 Service to Mankind Award.

BENNETT E. SMITH, JR., of Hattiesburg held open house during March for his new Hattiesburg Adolescent Clinic at 212 South 27th Avenue.

PRENTISS SMITH, a resident in radiology at UMC, will associate with DAN KEEL of Brookhaven.

JAMES P. SPELL of Jackson announces the relocation of his offices to 385 Medical Drive.

EDSEL F. STEWART of McComb announces the relocation of his clinic for the practice of obstetrics and gynecology to 212 Marion Avenue, across from Southwest Mississippi Regional Medical Center.

CECIL T. WILLIAMS, JR., of Laurel was guest speaker at the Laurel Exchange Club. Dr. Williams discussed cardiovascular diseases.

JOHN CLARK WILLIAMS of Vicksburg attended the postgraduate course of the University of Miami School of Medicine which covered recent advances in the diagnosis and management of internal medicine disorders.

POSTGRADUATE CALENDAR

June 3-4, 1976

PHYSICIAN EMERGENCY CARE COURSE
University Medical Center, Jackson

The University of Mississippi Medical Center Division of Continuing Health Professional Education offers courses to meet physicians' clinical practice needs in areas most requested. All correspondence about course offerings should be addressed to Continuing Education, University Medical Center, 2500 North State Street, Jackson, MS 39216.

LETTERS

SIRS: Scabies (itch), head, body and pubic lice are continuing to be widely reported throughout Mississippi and the United States. Reports indicate that these conditions have been increasing worldwide.

Traditionally, these conditions were thought to be associated with war, social upheaval and poverty. However, it now appears that the diseases have epidemic cycles of 12 to 15 years and the relationship with social unrest and poverty reflects the persistence of these social conditions. The infestations are no respectors of socioeconomic status. Just as military troops were readily available for examination, school children provide obvious groupings of individuals wherein infection is more easily found. However, school settings are no more likely to spread these diseases than are other areas of social contact. Certainly, closing of schools has had no noticeable effect on outbreaks.

These diseases are transmitted from person to person through "skin-to-skin" contact and, to a lesser extent, through contaminated clothing and bedding.

If one family member has one of these conditions, it is likely that others will have it. Therefore, all family members should be treated at the same time. Transmission between families generally occurs via children who have close contact as playmates; therefore, close, non-family contacts should be examined.

Untreated, these conditions may persist for decades, but treatment is nearly 100 per cent effective provided that simple details are strictly followed. Each person should take a hot, soapy bath, vigorously scrubbing the infected areas. After drying with a clean towel, apply 1 per cent lindane cream or lotion (many products are available without prescription). For scabies, apply from the neck down and allow to remain, undisturbed by washing, for 24 hours. At the end of 24 hours, another hot bath is taken and clean clothing put on. For lice, shampoo the head or other affected area thoroughly. All clothing, bed clothes, blankets, towels, wash cloths, etc., should be laundered, steamed or otherwise cleaned, and this should be repeated frequently. Repeat this entire process in one week. Nits are not removed by this process but they are rendered inactive. Complete cooperation is necessary to achieve and maintain freedom from these pests.

Though closing of the schools is not indicated, physicians, nurses, parents, and teachers must maintain a high index of suspicion for these conditions and must work in close cooperation. Children suspected of having one of these conditions should be promptly excluded from school and re-admitted only on certificate from the physician.

Though body lice may transmit other disease agents, such concern is premature at this time. Prompt control of lice infestations will prevent any possible occurrence of other louse-borne diseases. Scabies, head lice and pubic lice do not transmit other disease agents.

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health

Female Alcoholics Studied at UMC

Physicians who have female patients with a drinking problem may refer them to the University of Mississippi Medical Center for treatment in a new Department of Psychiatry and Human Behavior study.

"We're not necessarily looking for women who have been diagnosed 'alcoholic,'" said Dr. Marie Mastria, instructor in psychiatry (psychology) and coordinator for the study. "And for comparison purposes, we need other women volunteers who are moderate social drinkers with no drinking problem."

Most past treatment for women is based on information about male drinkers, the coordinator said. "Women may develop drinking problems for different reasons than men."

Each woman in the study will be evaluated so treatment can be individualized according to her special needs.

The other volunteers, of course, will not have treatment.

UMC investigators believe the longterm study will help find effective ways of treating women with drinking problems.

There is no charge for participation.

Dr. Berman's Family Presents Gifts to UMC

The family of the late Dr. Maxwell D. Berman of Jackson has given part of the physician's laboratory supplies and equipment to the University of Mississippi Medical Center.

Dr. Berman served as a family physician and general surgeon in Jackson until his death in April 1975.

"This generous gift will strengthen the educational program for our medical technology students," said Dr. Thomas E. Freeland, dean of the School of Health Related Professions at the Medical Center. "We are grateful for the Berman family's interest in and support of this program."

Assistant professor of medical technology Ms. Frances Freeman said the gift will provide students an opportunity to learn about lab work in a doctor's office as well as in a medical center setting.

"The equipment in a large teaching hospital and medical center is necessarily automated and computerized," she explained. "Lab supplies and equipment used in a doctor's office are usually manual and place the technologist in the responsible position of making more decisions," she said.

Dr. Berman earned his M.D. degree at Vanderbilt University School of Medicine in 1931.

Survivors are his widow, Mrs. Maxwell D. Berman of Jackson; a son, Dr. Walter Berman, fellow in cardiology at the Medical Center; a daughter, Mrs. Allen G. Donn of Norfolk, Va.; and two grandchildren.

May Is National High Blood Pressure Month

May 1976 has been designated as High Blood Pressure Month. More than 150 national organizations and their affiliates, including MSMA, are participating and helping to focus national attention on the nature and control of this silent disease.

Statistics show that one out of every ten Americans has hypertension and only one out of ten victims has his or her blood pressure under control.

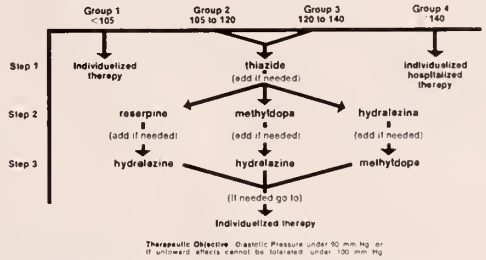
The goal is to increase the effectiveness and activity of all who are involved in hypertension control, thereby leading to a gradual reduction in the prevalence of hypertension.

Last May during the first national high blood pressure month, nearly 1,000 community groups reported participation in this effort, which resulted in more than a million persons screened, 150,000 referred to a physician for diagnosis and possible treatment, and an estimated 75 per cent of the population exposed to high blood pressure messages in the broadcast media. It is hoped that even more people will be reached during May 1976 and that activities will be started that can be continued year-round.

The 108th Annual Session of the MSMA is during May. Special activities related to hypertension include an exhibit on the subject by the Mississippi Heart Association and a special guest speaker at the Section on Preventive Medicine. Dr. Joseph A. Wilber, supervisor of Adult Health Services, Georgia Department of Human Resources in Atlanta, will discuss Hypertension—A Community Affair at the section meeting on May 5, beginning at 1:30 p.m. in the Willow II Room of the Holiday Inn Downtown.

The American Heart Association has numerous educational pamphlets which are suitable for physicians' waiting rooms. For a listing of what is available and how to order them, contact the Mississippi Heart Association, P.O. Box 16063, Jackson, MS 39206.

Outline of Recommended Antihypertensive Regimens for Groups with Veryingly Severe Hypertension as indicated by Diestolic Pressure (in mm Hg)



Therapeutic Objective. Diastolic Pressure under 90 mm Hg or if untoward effects cannot be tolerated under 100 mm Hg

"All hypertensives should have treatment for any lipid disorder and obesity and should be instructed to stop smoking cigarettes and to engage in appropriate regular exercise." Report of Inter-Society Commission for Heart Disease Resources, Circ Vol XLIV, Nov 1971

Basic Dosage and Time Recommendations for Antihypertensive Regimens

DRUG DOSAGE*	Group 2 Diastolic pressure 105 to 120 mm Hg		Group 3 Diastolic pressure 120 to 140 mm Hg	
	Initial dose (mg/day)	Maximum dose (mg/day)	Initial dose (mg/day)	Maximum dose (mg/day)
Diuretics	(Begin with half dose and increase in one step to full dose if needed)		(Begin with full dose)	
Reserpine	0.1	0.25	0.1	0.25
Methyldopa	500	2000	750	3000
Hydralazine	30	200	75	300
Time interval	**Average interval (months)**	**Maximum interval (months)**	**Average interval (months)**	**Maximum interval (months)**
Interval between visits while BP is being lowered	½	2	¼	1
Interval between visits when BP is under control	2	4	2	4
Interval between re-examinations and repeat lab work	6	12	6	12

*Diuretics and reserpine can be given in single daily doses. Methyldopz and hydralazine should be given in 2 to 4 divided doses

For complete information on action, side effects, and contraindications of antihypertensive drugs, see "Hypertension Drug Treatment 1973 and "Hypertension Office Evaluation 1972, American Heart Association

Available Oral Diuretics

	Full Dose (mg/day)
A. SULFONAMIDE DERIVATIVE DIURETICS	
Thiazides	
Chlorothiazide	1000
Flumethiazide	1000
Hydrogenated Derivatives	
Hydrochlorothiazide	100
Hydroflumethiazide	100
Substituted Compounds	
Bendroflumethiazide	5
Benzthiazide	100
Trichlormethiazide	4
Methyclothiazide	5
Polythiazide	8
Cyclothiazide	2
Chlorthelidone	100
Quinethazone	100
B. POTASSIUM-SPARING DIURETICS	
Spironolactone	100
Triamterene	300
C. NON-SULFONAMIDE DIURETIC AGENTS –	
Most potent oral diuretics, but more liable to induce side effects than milder agents	
Furosemide	80
Ethacrynic acid	100

Antihypertensive Drug Data

	Usual daily dose (mg)	
	Initial	Maximal
A. RAUWOLFIA ALKALOIDS		
Reuwoltia (whole root)	100.0	200.0
Alseroxylon	1.0	2.0
Reserpine	0.1	0.25
Deserpidine	0.25	0.25
Rescinnemine	0.25	2.0
Syrosingopine	1.0	3.0
B. METHYLDOPA	500.0	3000.0
C. HYDRALAZINE	50.0	300.0
D. GUANETHIDINE	12.5	No limit
E. GANGLION BLOCKING AGENTS		
Mecamylamine	2.5	No limit
Pentolinium	2.5	No limit

Outline of recommended antihypertensive regimens.

DEATHS

OVERBY, JAMES A., Jackson. Born Bruce, MS, Dec. 23, 1933; M.D., University of Mississippi School of Medicine, Jackson, MS, 1962; interned Mississippi Baptist Hospital, Jackson, MS, one year; radiology residency, University of Arkansas, Little Rock, AR, 1970-72; radiology residency, Charity Hospital, New Orleans, LA, 1972-73; died Mar. 24, 1976, age 43.

PEELER, JOSEPH G., SR., Shaw. Born May 7, 1904, Shannon, MS; M.D., University of Tennessee College of Medicine, Memphis, TN, 1935; Interned Lloyd Memorial Hospital, Fairfield, AL, one year; died Mar. 7, 1976; age 72.

RAYBURN, THEODORE H., Pontotoc. Born Etta, MS, Oct. 31, 1906; M.D., University of Tennessee College of Medicine, Memphis, TN, 1931; interned Natchez Charity Hospital Natchez, MS, one year; died Mar. 4, 1976, age 69.

VICK, WALTER D., Grenada. Born Water Valley, MS, June 1, 1927; M.D., University of Tennessee College of Medicine, Memphis, TN, 1957; interned Medical Center, Columbus, GA, one year; ob-gyn residency, Kaplolania Hospital, Honolulu, Hawaii, 1964-67; died Mar. 21, 1976, age 48.

Louisiana-Mississippi O and O Society Meets

The Louisiana-Mississippi Ophthalmological and Otolaryngological Society will hold its annual meeting May 27-30 at the Grand Hotel, Point Clear, AL.

Ophthalmology speakers are John E. Harris, Ph.D., M.D., Professor and Chairman of the Department of Ophthalmology, University of Minnesota Medical School, and Kenneth Swann, M.D., Professor and Chairman, Department of Ophthalmology, University of Oregon. Otolaryngology speakers are Phillip M. Sprinkle, M.D., Professor and Chairman, Department of Otolaryngology, University of West Virginia, and James A. Crabtree, M.D., practicing otolaryngologist of Los Angeles.

Dr. James H. Allen, Professor and Chairman Emeritus of Tulane School of Medicine, will be presiding as president of the society.

BRIEF SUMMARY OF
PRESCRIBING INFORMATION
ANTIMINTH® (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

ROERIG Pfizer

A division of Pfizer Pharmaceuticals
New York, New York 10017

One swallow does it



eliminates Pinworms and Roundworms with a single dose

- **Single dose effectiveness against both pinworms and roundworms**—The only single-dose anthelmintic effective against pinworms *and* roundworms.
- **Nonstaining**—to oral mucosa, stomach contents, stools, clothing or linen.
- **Well tolerated**—the most frequently encountered adverse reactions are related to the gastrointestinal tract.
- **Economical**—a single prescription will treat the whole family.
- **Highly acceptable**—pleasant-tasting caramel flavor.
- **Convenient**—just 1 tsp. for every 50 lbs. of body weight. May be taken without regard to meals or time of day.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Please see prescribing information on facing page. NSN 6505-00-148-6937

Antiminth® ORAL SUSPENSION
(pyrantel pamoate) equivalent to 50mg pyrantel/ml

ORGANIZATION / Continued

Mammography Courses Are Offered

The University of Texas Cancer Center at Houston will offer a one week mammography training course the second or third week of each month, beginning May 17.

A maximum of four physicians and four technologists may register per course. Each course will be held Monday through Friday and eight hours of instruction will be given each day.

There is no fee and the course carries category 1 credit for AMA Physician's Recognition Award and American College of Radiology and is approved for ECE points by ASRT.

For information write Dawn N. Shull, Project Coordinator, Department of Diagnostic Radiology, M. D. Anderson Hospital and Tumor Institute, 6723 Bertner Drive, Houston, TX 77030.

Surgeons Attend Third Surgical Forum



Some 350 surgeons from 36 states and Puerto Rico gathered in Jackson for the third University of Mississippi Medical Center surgical forum. Participants who heard lectures and panel discussions on general, vascular, stomach, and biliary tract surgery included, from left, Dr. M. Beckett Howorth, Jr., Oxford, MS; and Dr. H. S. Jeck, Oxford, Ohio. The medical school surgery department and UMC continuing education division sponsor the three-day event each year.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

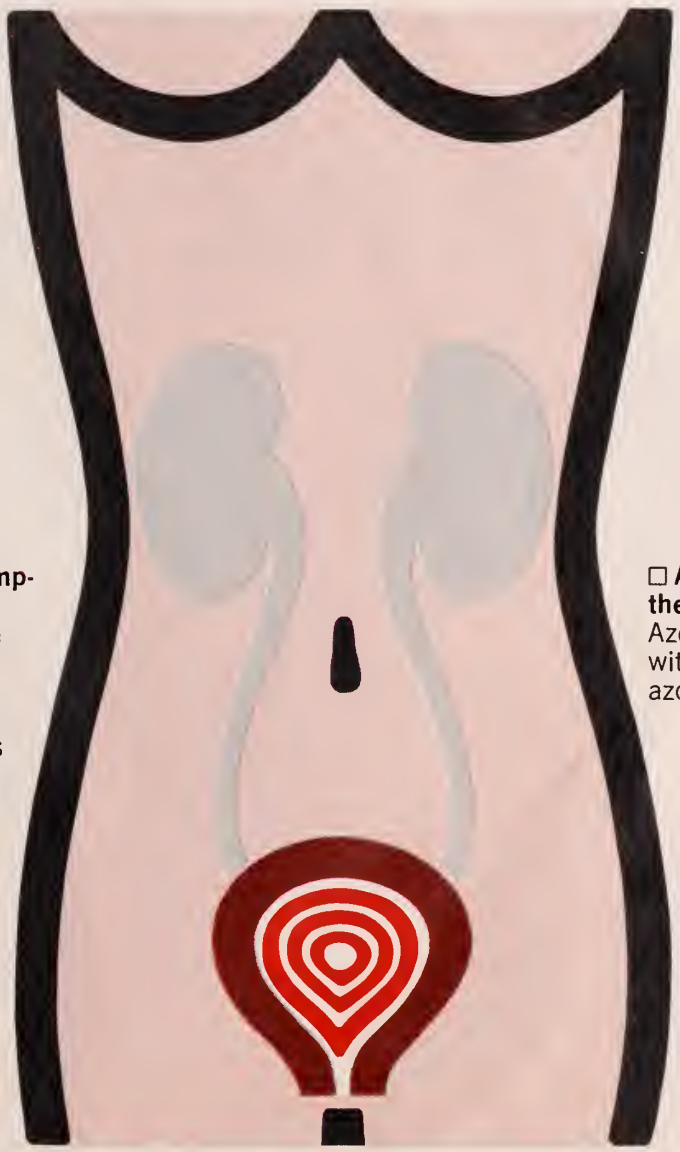
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

When pain complicates acute cystitis*

Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

for the pain for the pathogens



☐ **Early relief of painful symptoms** such as burning and discomfort associated with urgency and frequency.

☐ **Effective control of susceptible pathogens** such as *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris.*

☐ **Appropriate antibacterial therapy:** up to three days with Azo Gantanol, then 11 days with Gantanol® (sulfamethoxazole).

*nonobstructed; due to susceptible organisms

ROCHE

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

FOR LONG-TERM CONTROL OF HYPERTENSION*

Serum K^+ and BUN should be checked periodically. (See Warnings Section.)



Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

*

Warning

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

***Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F Co., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

Upjohn

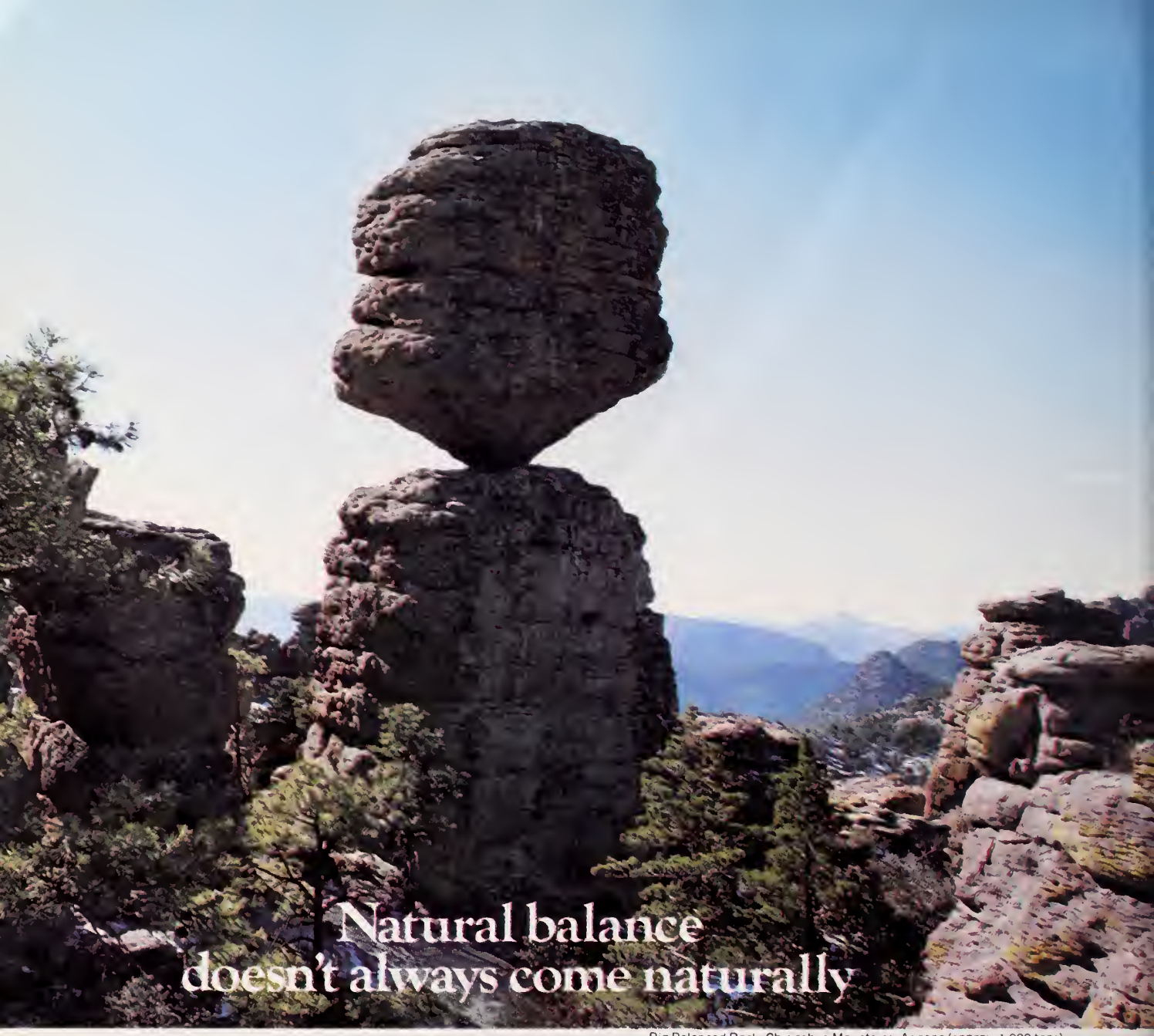
The Upjohn Company, Kalamazoo, Michigan 49001

Medrol® 4 mg Dosepak*

methylprednisolone, Upjohn

The explicit printed dosage instructions that accompany each Dosepak make it easy for the patient to understand and follow the dosage regimen.





Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

□ Found useful in the management of vertigo* associated with diseases affecting the vestibular system.
□ Can relieve nausea and vomiting often associated with vertigo.*
□ Usual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.
□ Also available as Antivert (meclizine HCl) 12.5 mg. scored tablets, for dosage convenience and flexibility.
□ Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for nausea, vomiting and dizziness associated with motion sickness.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

Med Center Forum Reunites M*A*S*H Buddies

Mississippi surgeons Dr. J. H. Holleman of Columbus and Dr. Agrippa S. Kellum of Tupelo talked over "old times" with Korean war buddy Dr. Richard Hornberger of Waterville, Maine, at the University of Mississippi Medical Center surgical forum during April in Jackson.

The three were together 23 years ago at the Mobile Army Surgical Hospital which Dr. Hornberger (under the pen name Richard Hooker) has made famous in his novel *M*A*S*H*. Dr. Holleman was commanding officer of the unit and Drs. Kellum and Hornberger were surgeons on his staff.

Dr. Hornberger, a general and chest surgeon who received his M.D. degree from Cornell, said he had always been interested in writing as a hobby and was on his school and college newspaper staffs. He thinks his journalistic endeavors helped him get accepted to medical school as his marks were not the highest.

It took the surgeon-author about 10 years to write the novel and the book was rejected by 17 consecutive publishers. He feels that the movie helped make his book a success, and it is now published in 12 languages.

When asked what was it really like in Korea, the three M*A*S*H veterans said they had to work very hard when there were casualties but that when things were slow, they played just as hard. They played a lot of poker. Conditions were harsh; for example, the shower unit came once a week.

The medical unit consisted of 12 people "miles from nowhere and things were not very political there." Dr. Hornberger said the doctors knew they could do what they liked as long as they got the job done.



Mississippi surgeons Dr. J. H. Holleman of Columbus, center, and Dr. Agrippa S. Kellum of Tupelo, right, talk "old times" with Korean war buddy Dr. Richard Hornberger of Waterville, Maine.

Drs. Hornberger and Kellum were in Korea for 16 months and with the M*A*S*H unit for a year. Dr. Holleman was commander when they arrived and he was sent back to the states six months later.

The surgeons were often called upon to operate on members of the U.N. forces in Korea and many patients came from the Black Watch of Scotland.

The M*A*S*H unit held a grand reunion three years ago in Evansville, IL, according to Dr. Hornberger. These three have kept in touch and Drs. Kellum and Holleman have visited the Hornbergers and their five children in Maine. Another key figure, familiar to movie fans, is Trapper John who is now a government official.

Dr. Hornberger has written two more books consisting of short stories about the Korean experience and afterward. He and Trapper John plan to do a book which will be medically oriented but different from M*A*S*H. Although authorship brings him in contact with some interesting people, the author says he is still a physician first and that was the reason for his visit to Mississippi. As a rural practitioner, he is very conscious of the need for postgraduate education.

When asked his opinion of the book, Dr. Kellum said, "It is fairly representative of what really happened—about 98 per cent fiction and two per cent fact!"

Dr. Lamar Arrington Is Honored

Dr. Lamar Arrington of Meridian was honored by his peers at the bi-monthly meeting of the East Mississippi Medical Society at Northwood Country Club in Meridian.

Dr. Arrington, who was a practicing physician in Meridian from 1928 until his retirement in 1972, was presented an award for 50 years of medical practice and membership in the Mississippi State Medical Association. Dr. Jack A. Atkinson of Brookhaven, MSMA president, presented the award.

Dr. Arrington received his M.D. degree from Tulane University Medical School in 1925 and did postgraduate training at Touro Infirmary in New Orleans, Vicksburg Charity Hospital, Laurel Charity Hospital, Matty Hersee Hospital, and Barnes Hospital Group, St. Louis.

He is a past present of the Lauderdale County Medical Society and MSMA, which he also served as a member of the board of trustees for 22 years.

Mississippi Med Students Learn Family Practice

Mississippi medical students who'll graduate two years from now have a new assignment: live and learn in Mississippi communities.

Beginning in June, every third-year medical student at the University of Mississippi Medical Center will take a required three weeks in family medicine rotation in towns across the state.

The outreach program will put the students into areas where they may someday choose to locate. Many will return to their hometowns, where they'll learn about continuous, comprehensive, family-centered care from those who know it best: Mississippi's practicing family physicians.

"This experience," said Dr. Hardy B. Woodbridge, assistant professor of family medicine and program coordinator, "helps bridge the gap between the basic sciences and direct patient contact. Each student is exposed to the life of the community doctor and community health resources which complement the primarily academic setting at University Hospital in Jackson."

Since the UMC medical school added a Department of Family Medicine in 1973, senior medical students could choose a community training program with a practicing family physician in Jackson or another Mississippi town.

Nearly 100 UMC medical students have voluntarily participated in that program, beginning with 10 per cent of the 1973 graduating class and rising to a record 48 per cent of the current seniors. More than 60 per cent of the class of 1976 say they'll go into primary practice.

A DHEW Public Health Service grant has helped strengthen and expand the original UMC program, providing the community experience or "clerkship" for every third-year student and a second assignment or "preceptorship" as a senior elective. Participating students receive small stipends to help cover expenses.

For clerkships and preceptorships, the family medicine department matches students to community physicians. Criteria for the "match" include the size and location of the town, the type practice, and the participants' personal interests.

Community physician-teachers prepare for their educational roles in Department of Family Medicine regional workshops. The one-day sessions allow UMC faculty and the practicing physicians to discuss teaching methods and individual, but uniform, learning plans.

Students get ready for the outreach program in an intensive three-day orientation in the family medicine department. Faculty stress what students should learn, help students refine their interviewing and physical examination techniques, and set specific goals for the community experience.

Each local family physician takes a medical student as a member of his team for three weeks, helping the student learn to provide health care in the office, the home, the hospital, or nursing home.

Preceptorship sites range from small communities of 450 to cities of 180,000.

This approach in medical education follows a national trend among medical schools.

"Several schools have outreach programs," Dr. Woodbridge said, "but most do not restrict students to their own state as we do. Ours is the first we know of to emphasize the intense orientation for students or to offer regional workshops for qualifying the physicians as teachers.

"It's the approach, we believe," he said, "that will introduce students to family medicine early and help keep them instate to practice."

Dr. W. H. Stewart Will Address Commencement

Louisiana's commissioner of health, welfare, and rehabilitative services will address the University of Mississippi Medical Center 1976 degree candidates.

Dr. William Huffman Stewart will speak at the May 30 Commencement ceremonies beginning at 4 p.m. in the city auditorium in Jackson.

The 230 candidates include 115 candidates for the M.D. degree. Other students represent the nursing and health related professions schools and the graduate program in the health sciences.

Dr. Stewart is on leave from the Louisiana State University School of Medicine, where he holds the rank of professor of pediatrics and of preventive medicine and public health. From 1969 to 1974 he served as chancellor of the LSU Medical Center.

Former surgeon general, United States Public Health Service, he has also served as director of the National Heart Institute, National Institutes of Health.

Dr. Stewart earned his M.D. degree at LSU School of Medicine in New Orleans in 1945, interned at Philadelphia General Hospital, PA, and did a residency in pediatrics at Charity Hospital of Louisiana.

Author or coauthor of more than 70 scientific articles, he is a member of a dozen professional or-

ganizations, including the Association of Military Surgeons, American Board of Pediatrics (diplomate), and American College of Cardiology (fellow).

Dr. Wiser Is New Head of Ob-Gyn Department

Dr. Winfred Wiser has been named chairman of the Department of Obstetrics-Gynecology at the University of Mississippi Medical Center. Vice Chancellor Dr. Norman C. Nelson announced the appointment following action of the Board of Trustees of Institutions of Higher Learning.



Dr. Wiser

Dr. Wiser, who joined the UMC faculty April 15, succeeds Dr. Henry Thiede. Dr. Richard Boronow, professor, has been acting chairman of the department.

Formerly professor of obstetrics-gynecology at the University of Tennessee School of Medicine, Memphis, Dr. Wiser was once an assistant professor of ob-gyn at the Mississippi school.

He earned his M.D. degree at the medical school in Memphis in 1952, did an internship at John Gaston Hospital in Memphis, and came to University Hospital in Jackson for a three-year residency in ob-gyn. The David Lipscomb College in Nashville alumnus also holds a B.S. degree from Middle Tennessee State University, Murfreesboro.

Dr. Wiser is the author or coauthor of 70 scientific papers. His articles have appeared in *Obstetrics and Gynecology, Journal of Clinical Endocrinology, American Journal of Obstetrics and Gynecology, Journal of Reproductive Medicine, Southern Medical Journal,* and *Surgery.*

The new UMC department chairman is a member of several professional organizations, including the American Medical Association, American College of Surgeons, American College of Obstetricians and Gynecologists, and the Association of Professors of Gynecology and Obstetrics.

Dr. Wiser has been on the University of Tennessee faculty since 1968. He was in general practice for five years before beginning residency training at UMC and in the private practice of obstetrics-gynecology for five years before joining the UMC faculty in 1967.

Shock Is Studied at Medical Center

A University of Mississippi Medical Center research team is studying the effects of shock on phagocytosis to provide another clue in the prevention of shock fatalities because of infection.

Kenneth Groue, a senior at Millsaps College in Jackson, participating in a research project at UMC, presented the findings at the 60th annual conference of the Federation of American Societies for Experimental Biology in Anaheim, Calif. Dr. Virginia Lockard, assistant professor of pathology at the Medical Center, is co-investigator.

In a previous study, Dr. Lockard found that the phagocytic cells in shocked laboratory animals can ingest bacteria but cannot kill them.

Groue's research has focused on the enzymes in phagocytic cells, produced when the cells kill invading bacteria.

The team found a significant decrease in the enzyme levels of the shocked animals.

Further research could pinpoint reasons why enzymes fail to act in the aftermath of shock, and thus provide answers to infection prevention in shock victims.

The UMC study was supported by a Mississippi Heart Association grant.

Medical Center Hosts ACP Course



The University of Mississippi Medical Center-hosted American College of Physicians hematology/oncology course drew some 75 physicians from 26 states and Mississippi. One of eight nationally known specialists on the guest faculty was Dr. Mario G. Baldini, right, professor of medical science at Brown University, Providence, RI. With him are, from left, Dr. Van Lackey, UMC fellow in hematology/oncology; Dr. Ralph Vance, fellow in cardiology; and Dr. Francis Morrison, associate professor of medicine and director of the division of hematology.

No. 3
As potent as the pain it relieves.

e.g. the pain of
surgical convalescence



NOT TOO LITTLE

- as potent as the pain you need to relieve in patients with fractures, sprains, strains, wounds, contusions, and the pain of surgical convalescence
- unlike acetaminophen/codeine combinations, it does not sacrifice anti-inflammatory action

NOT TOO MUCH

- potent—yet not excessive
- addiction liability low

NOT TOO EXPENSIVE

- brand-name quality, yet reasonable in cost
- readily available in both hospital and local pharmacies

CONVENIENCE

- telephone Rx in most states, up to 5 refills in 6 months at your discretion (where state law permits)

EMPIRIN® COMPOUND WITH CODEINE NO. 3

codeine phosphate* (32.4 mg) gr ½
Each tablet also contains: aspirin gr 3½, phenacetin gr 2½, caffeine gr ½. *Warning—may be habit-forming

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Dr. Curtis Artz Speaks at Surgical Forum



Guest faculty member Dr. Curtis P. Artz, left, joins Dr. John M. McRae of Laurel during the University of Mississippi Medical Center surgery forum in Jackson. Dr. Artz, professor of surgery and chairman of the department at the Medical University of South Carolina, was on the Mississippi medical school faculty when Dr. McRae was a surgery resident at UMC. Centering much of his research in the area of surgical metabolism, shock, and burns, Dr. Artz was a founding member and first president of the American Burn Association.

UMC Juniors Begin 48-Week Curriculum

Junior medical students at the University of Mississippi Medical Center will begin a new 48-week curriculum this summer.

The change is designed for the 150 UMC students who entered in 1974 and are reaching their third year. Existing facilities and faculty can't accommodate the number in the regular school year.

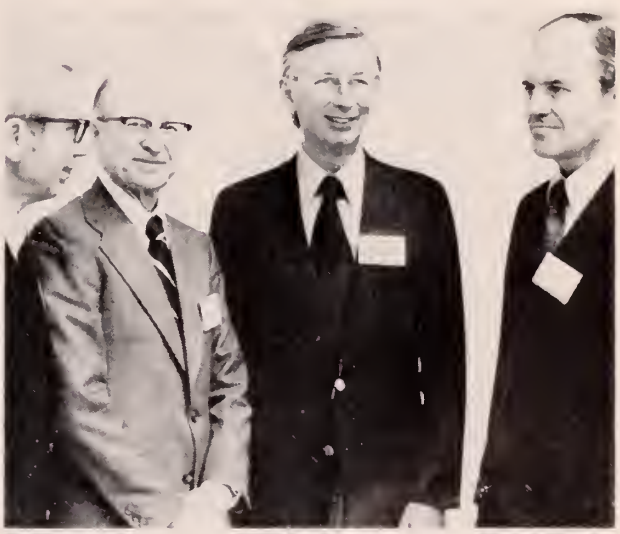
"The year-round curriculum allows more teaching in the hospital," said UMC vice chancellor and medical school dean Dr. Norman C. Nelson. "The longer school year will give the big classes the needed involvement in patient care until we can find a better way to meet the need."

On June 28, the earliest starting date in the Medical Center's 20-year history, juniors will begin rotation of clinical assignments and vacation periods. The students, in 16 groups, continue the rotation until June 21, 1977. Each group has a different three-week vacation period in addition to the traditional school holidays.

Increased appropriations from the state legislature in 1974 supported a UMC freshmen enrollment increase to 150 that fall, a 23 per cent jump over the previous year's registration.

Dr. Nelson said that larger state appropriations allowed an expansion of basic science faculty. But thus far, funds have not been sufficient to add clinical faculty or more teaching hospital facilities.

Med Center Hosts Miss-La ACP Meet



Scientific sessions of the Mississippi-Louisiana regional meeting of the American College of Physicians at the University of Mississippi Medical Center drew more than 100 participants. Program faculty included the ACP president-elect, Dr. James Albert Clifton, second right, chairman of the University of Iowa's Department of Medicine, and Dr. Marion Hargrove, Louisiana ACP governor. With them are Dr. Guy D. Campbell, second left, Mississippi ACP governor and UMC professor of medicine, and Dr. Thomas Blake, UMC professor of medicine, and governor-elect.

Counsel to Authors

THE JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, Miss. 39216, in original and at least one duplicate copy. They must be typewritten double spaced on 8½ by 11-inch white bond paper with a standard typewriter.

The author is responsible for all statements made in his work, including changes made by the manuscript editor. Manuscripts are received with the understanding that they are not under simultaneous consideration by any other publication and have not been previously published. All manuscripts will be acknowledged, and while those rejected are generally returned to the author, the JOURNAL is not responsible in event of loss. Manuscripts accepted for publication become the property of the JOURNAL and are copyrighted by the association when published. They may not be published elsewhere without written release and permission from both the JOURNAL and the author.

All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10, but when justified to the Editors, additional references will be considered for publication. Each will be critically examined, and only valid, primary references will be published. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus,* volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made after proof sheets are received by the JOURNAL.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for illustration engravings not exceeding four column inches per printed page.

Illustrations must be numbered and cited in the text. Legends, not exceeding 40 words and preferably shorter, must accompany each illustration, typed double spaced on separate sheets. The following information should appear on a gummed label affixed to the back of each illustration: Figure number, manuscript title, author's name, and arrow indicating top of the illustration.

In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

A thesis summary of 75 to 100 words must accompany each manuscript separately from the text.

Reprints may be obtained at cost plus shipping charges from the association and should be ordered prior to publication. The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. —*The Editors.*

CLASSIFIED

FULL-TIME ER PHYSICIAN—for modern, expanding, fully-accredited 467-bed regional medical center with low malpractice ins. rates, salary and fringes negotiable, progressive staff with specialty back up. Excellent schools, college facilities, cultural activities, recreational activities. Contact Dan S. Wilford, Adm., North Mississippi Medical Center, 830 South Gloster St., Tupelo, MS 38801. (601) 842-3632.

NEEDED: One physician to work in an active University Student Health Center beginning July 1, 1976. Please contact J. C. Longest, M.D., Director, Mississippi State University, P. O. Box 5448, Mississippi State, Miss. 39762. Phone: 1-601-325-2431.

Want to settle in Jackson? Ideal location next to Memorial Stadium. Three months' free rent to right party. Write in confidence to: MD, Box 5273, Fondren Station, Jackson, MS 39216.

JOIN MPAC TODAY

Index to Advertisers

Blue Cross-Blue Shield of MS . . . 12
Burroughs Wellcome Co. . . . 148

Canton Exchange Bank . . . 14
Coca-Cola . . . 17

Fulltime ER Physician Needed . . . 19

Hill Crest Hospital . . . 18
Hyrex-Key Pharmaceuticals . . . 11

Key Pharmaceuticals, Inc. . . . 15

Eli Lilly and Co. . . . front cover

Mead Johnson . . . 8
Mississippi State University . . . 19
Mississippi Stationery Company . . . 16

Office for Lease . . . 19

Pennwalt Prescription Products . . . 136B, 136C, 136D
Pharmaceutical Manufacturers Assoc. . . . 6, 7
Premier Printing Co. . . . 16

A. H. Robins Co. . . . 10A, 10B
Roche Laboratories . . . second cover, 3, 144, 144A, third and fourth covers
Roerig and Co. . . . 142, 143, 144D

Smith Kline and French . . . 144B

The Upjohn Company . . . 144C

Volunteers of America . . . 10

Wayne Medical Laboratory, Inc. . . . 17

Thomas Yates and Co. . . . 4

IN CONCLUSION

"The number of dogs in the United States should be drastically reduced," proposes Dr. Robert M. Goldwyn of Brookline, MA, in Archives of Surgery. He points out that at least one million persons in the U.S. each year suffer from dog bites. The largest number of victims are children younger than 12 and some of them will bear emotional, as well as physical, scars for many decades, he says. Dr. Goldwyn called for birth control of dogs, stricter enforcement of leash laws, and impoundment of all strays, along with health monitoring and inoculations.

"Preparation for Parenthood Through Group Discussion" is the title of a 58-page booklet published by Johnson & Johnson for nurse-leaders of expectant-parent discussion groups. The guide was written by Aline B. Auerbach, parent group consultant and former director of parent group education and leadership training for the Child Study Association of America, Inc., to help nurses conduct classes for expectant parents through guided group discussion. Copies are available at no charge through Patient Care Division, Johnson & Johnson, New Brunswick, NJ 08903, Dept J-208.

Statistics compiled by HEW's National Institute of Mental Health indicate that an increase in the number of persons with mental disorders could occur during the next decade. Two major factors support this prediction: 1) projected large increases in population of age groups characterized by high incidence rates of mental disorders and high admission rates to various types of psychiatric facilities and 2) improvements in medical and psychiatric care and public health practice that increase the lifespan of persons with mental disorders.

The fifth HEW annual report on marihuana and health "does not give marihuana a clean bill of health," states Dr. Robert DuPont, National Institute on Drug Abuse director. "Nor does it support the fear and irrationality that still characterize some of the public debate on marihuana." Hazards of marihuana use pointed out by Dr. DuPont include impairment while intoxicated on marihuana of psychomotor skills used in driving and many industrial jobs, and the adverse influence of the drug on intellectual performance, particularly immediate memory.

AFL-CIO executive council announced a national effort to clean up the nation's nursing homes, which it said were in many cases a scandal and a disgrace. "While there are some nursing homes...that provide good care through conscientious management, the scandals continue to mount up. Unscrupulous nursing home operators, medical laboratories, clinics, doctors, medical appliance salesmen, and insurance company executives are skimming their share off the top of the Medicare and Medicaid programs, reducing care for the elderly and subverting public support of the programs."

LIBRIUM®
(chlordiazepoxide HCl)

FOR ALL THE RIGHT REASONS.

- prompt and specific action
- documented benefit-to-risk ratio
- three dosage strengths to meet most therapeutic needs



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)
Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

LIBRIUM®
chlordiazepoxide HCl/Roche
5 mg, 10 mg, 25 mg capsules

Please see following page.

LIBRARY
MAY 25 1976
NEW YORK ACADEMY OF MEDICINE

N.Y. ACADEMY OF MED
EAST 103RD ST
EW YORK N.Y.
10029

LIBRIUM®
(chlordiazepoxide HCl)

FOR ALL THE RIGH REASONS.

Yesterday's decision to use Librium for a clinically anxious patient was based on several good reasons. Safety. Effectiveness. Versatility. And the reasons you chose it yesterday are as valid today.

Librium has accumulated an unsurpassed clinical record. A record validated in several thousand papers published both here and abroad.

Librium, when used in proper dosage, rarely interferes with a patient's mental acuity or ability to perform. However, as with all CNS-acting agents, good medical practice suggests that patients be cautioned against hazardous activities requiring complete mental alertness.

Librium has an established safety record and a documented benefit-to-risk ratio. And Librium is used concomitantly with such drugs as cardiac glycosides, diuretics, anticholinergics and antacids.

So when you consider antianxiety therapy, consider Librium. It's a good choice. For today. And tomorrow.



ROCHE

PROVEN ADJUNCT FOR CLINICAL ANXIETY

LIBRIUM® C IV

chlordiazepoxide HCl/Roche

Please see preceding page for summary of product information.

AMERICAN REVOLUTION BICENTENNIAL 1776-1976

JOURNAL OF THE Mississippi STATE MEDICAL ASSOCIATION

JUNE 1976

BALCONY
New from Lilly/Dista Research

NALFON®
fenoprofen calcium
300-mg.* Pulvules®

DISTA
Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

Additional information available to the profession on request.

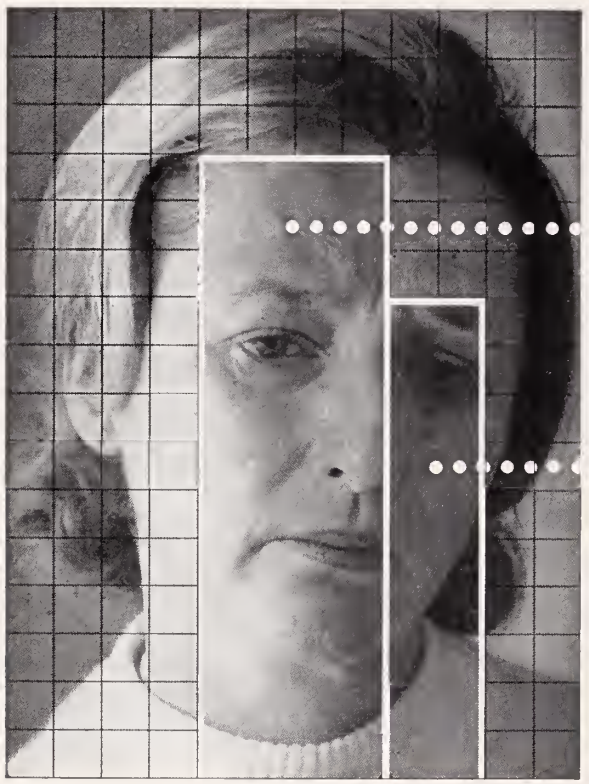
*Present as 345.9 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. fenoprofen.

600091

This Month . . . The Undescended Testis, Computerized Axial Tomography, Coverage of the 108th Annual Session

M.S.M.A

Both often



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic anxiety states with associated depressive symptoms

urveillance because of their predisposition to habituation and dependence. In regnancy, lactation or women of childearing age, weigh potential benefit gainst possible hazard.

recautions: If combined with other psychotropics or anticonvulsants, consider arefully pharmacology of agents emloyed; drugs such as phenothiazines, arcotics, barbiturates, MAO inhibitors nd other antidepressants may potentiate s action. Usual precautions indicated in atients severely depressed, or with latent epression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Heart Association Schedules Annual Meeting

The Mississippi Heart Association's 25th Annual Meeting will be held June 10-11 at the Coliseum Ramada Inn, and Mississippi Power and Light Lodge, Jackson, according to Dr. Cecil Williams, chairman of the Planning Committee.

Scheduled for the afternoon of June 11 at the Ramada Inn is an update seminar on heart disease entitled "Heart Facts Forum." Moderating the session will be Dr. Williams. Speakers and their subjects will include: Harper K. Hellems, M.D., "Magnitude and Scope of the CV Problem"; Quinton Dickerson, M.D., "Examination and Evaluation of the Heart Patient"; Patrick Lehan, M.D., "Medical Treatment of the Heart Patient"; Jeff Hollingsworth, M.D., "Surgical Treatment of the Heart Patient"; Clifford Tillman, M.D., "Newer Concepts of Coronary Care"; John Jackson, M.D., "Risk Factors in Heart Attack and Stroke"; Osrow Ellis, "Basic Life Support in Cardiac Arrest (CPR)."

A special 25th Anniversary social salute to past Heart Association presidents is scheduled at 7 p.m. on June 10 at the Mississippi Power and Light Company Lodge, Jackson.

Co-sponsoring the event are the Auxiliary to the Mississippi State Medical Association and the Mississippi Heart Association. Serving as Master of Ceremonies at the program will be Lt. Gov. Evelyn Gandy, who is serving as this year's Heart Fund Chairman.

Physician past presidents include: T. E. Wilson (deceased), Joseph Melvin, W. K. Purks, Arthur C. Guyton, D. J. VanLandingham, Wesley W. Lake, J. Manning Hudson, Lucian Ferris, Raymond F. Grenfell, Eugene Murphey, J. P. Tatum, G. Spencer Barnes, Frederick E. Tatum and William L. Wood, Jr.

Dr. Williams said, "The Mississippi Heart Association's annual meeting program will be of interest to physicians throughout the state. Doctors are invited and urged to attend."

For further information and reservations, contact: Mississippi Heart Association, Box 16063, Jackson, MS 39206.

Is there a tablet containing *only* an expectorant and *only* Glyceryl Guaiacolate? YES!

1. Patient acceptable tablet dose.
2. Single entity expectorant.
3. Measured tablet dose.
4. Sugar-free tablet.

An identifiable white, scored tablet which significantly stimulates the secretion of respiratory tract fluid.

HYTUSS TABS

(GLYCERYL GUAIACOLATE 100mg.)





Composition: Each sugar-free compressed tablet contains glyceryl guaiacolate 100mg. **Action and Use:** This preparation utilizes the effective expectorant action of glyceryl guaiacolate which significantly stimulates the secretion of respiratory tract fluid. The increased flow of less viscid fluid favors expectoration and has a demulcent effect on the tracheobronchial mucosa. The primary usefulness of Hytuss Tabs is to promote the change from a dry, unproductive cough to a productive cough. Hytuss is therefore useful in treating coughs due to the common cold, bronchitis, laryngitis, tracheitis, pharyngitis, influenza and the measles. The expectorant action of Hytuss may also provide symptomatic relief in some chronic respiratory disorders when the patient experiences spasms of dry nonproductive coughing. **Precautions:** Extremely large amounts may cause nausea and vomiting. **Administration and Dosage:** *Adults*—1 tablet four times daily. *Children*—6 to 12 years of age; ½ tablet 3 or 4 times daily. HOW SUPPLIED: White, scored, sugar-free, tablet in bottles of 100 - 1,000 - 5,000. **Product Identification Mark:** Hy. **Literature Available:** On request.

Available through all drug wholesalers.

Hyrex

HYREX COMPANY

832 South Cooper
Memphis, Tenn. 38104

Volume XVII
Number 6
June 1976



JOURNAL of the Mississippi
STATE MEDICAL ASSOCIATION

• EDITOR
W. Moncure Dabney, M.D.
• ASSOCIATE EDITORS
George H. Martin, M.D.
Myron W. Lockey, M.D.
• MANAGING EDITOR
Nola Gibson
• PUBLICATIONS COMMITTEE
Lawrence W. Long, M.D.
Chairman
Robert R. McGee, M.D.
T. A. Baines, M.D.
and the editors
• THE ASSOCIATION
Lyne S. Gamble, M.D.
President
James O. Gilmore, M.D.
President-Elect
J. Elmer Nix, M.D.
Secretary-Treasurer
C. D. Taylor, Jr., M.D.
Speaker
R. Faser Triplett, M.D.
Vice Speaker
Charles L. Mathews
Executive Secretary
H. Cody Harrell
Assistant Executive Secretary
William F. Roberts
Legal Counsel

The Journal of the Mississippi State Medical Association is owned and published monthly by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, $15.00 per annum; $2 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

CONTENTS

ORIGINAL PAPERS

The Undescended Testis **151** R. S. Hillis, M.D., and James E. Keeton, M.D., Jackson, MS

Computerized Axial Tomography **155** Michal A. Douglas, M.D. Jackson, MS

EDITORIAL

Thoughts on Annual Session **163** W. Moncure Dabney, M.D., Editor

THIS MONTH

The President Speaking **162** Convention in Jackson

Medical Organization **171** Dr. Lyne S. Gamble Is Inaugurated President, Dr. James O. Gilmore Is Named President-elect

Copyright 1976, Mississippi State Medical Association

TO COMPLETE YOUR HEALTH INSURANCE PICTURE, MSMA OFFERS ITS NEW COMPLETE HEALTH INSURANCE PACKAGE:

NEW MAJOR MEDICAL PLAN

Covers 80% of your eligible expenses after you satisfy your deductible amount. Choice of deductibles available. Pays expenses in and out of the hospital!

NEW HOSPITAL MONEY PLAN®

Pays a daily benefit for each day you spend in the hospital because of an accident or illness. Acceptance is GUARANTEED! Pays the benefits directly to *you*!

NEW EXCESS MAJOR MEDICAL PLAN

Picks up where basic insurance programs leave off. Pays 100% of eligible expenses in or out of the hospital—up to $250,000 maximum. And, premiums are LOW! Acceptance is GUARANTEED!

A complete health insurance picture is probably one of the most important items you can provide for your family's financial well-being. To help you combat the rising cost of hospital and medical care, MSMA has entirely revamped its health insurance program to give you the most complete and comprehensive program available . . . and at a low price all can appreciate. Find out more. Mail the coupon below for more information:

THE MSMA INSURANCE PROGRAMS ARE UNDERWRITTEN BY:

CONTINENTAL CASUALTY Co.
ASSOCIATION GROUP DIVISION
Chicago, IL 60685

a division of CNA/insurance

Please send me more details on the NEW MSMA insurance programs:

☐ **MSMA MAJOR MEDICAL PLAN** ☐ **MSMA HOSPITAL MONEY PLAN** ☐ **MSMA EXCESS MAJOR MEDICAL PLAN**

NAME_____

ADDRESS_____

CITY_____

STATE_____ ZIP CODE_____

MAIL TO: Thomas Yates & Co., MSMA Insurance Administrators
P.O. Box 1054, Jackson, Mississippi 39205

NEWSLETTER

June 1976

Dear Doctor:

The School of Nursing of the University of Southern Mississippi at Hattiesburg has received a $714,163 grant from the Department of HEW to initiate a project designed to upgrade the skills of professional nurses. The program aims to increase the knowledge and skill competencies of nurses; establish the delivery system for this upgrading; and establish a "bank" for training resource materials. There will be no fee to hospitals for assistance offered.

> Four Mississippi hospitals are currently participating as pilot projects: Marion County General Hospital in Columbia; Covington County Hospital in Collins; Perry County General Hospital in Richton; and Jones County Community Hospital in Laurel.

Those long debated Medicare certification and recertification requirements have now been dropped in hospitals whose medical staffs have implemented Professional Standards Review Organizations (PSRO) review. All Mississippi hospitals have been informed of the change in a letter from Medicare fiscal intermediary, Blue Cross-Blue Shield of Mississippi.

In keeping with authority granted by the county board of supervisors, the name of Lowndes General Hospital in Columbus has been changed to the Golden Triangle Regional Medical Center. The center announced plans to seek a certificate of need to allow for a $1.9 million expansion program for surgical and recovery facilities, intensive care unit and emergency room facilities.

More than 1.5 million Americans are spending an extra five days in hospitals each year as a result of infections contracted there, according to David J. Sencer, director of the Center for Disease Control in Atlanta. In his testimony before a House Appropriations subcommittee, he said that hospital infections constitute a $1 billion drain on the economy.

Please note: CHAMPUS - CHAMPVA has announced that the fiscal year has been changed for deductible accumulation for the two programs. The new fiscal year will run from October 1 through September 30. The present (1976) fiscal year will be extended from June 30 to September 30, 1976. For further information contact CHAMPUS, P. O. Box 5229, Jackson, MS 39216.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

Chest Physicians Announce Annual Assembly

"Clinical Implications and Projections in Cardiopulmonary Medicine and Surgery" will be the theme of the 42nd Annual Scientific Assembly of the American College of Chest Physicians. The medical meeting will be held at the Atlanta Hilton Hotel and Atlanta Civic Center, Atlanta, Oct. 24-28, 1976.

There is no registration fee for ACCP members, program participants, medical students, interns and residents. A fee of $75.00 will be required from non-member physicians. For further information, write Dr. Alfred Soffer, Executive Director, American College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068.

Jimmy Carter Supports National Health Insurance

Presidential candidate Jimmy Carter has abandoned his fence-straddling position on national health insurance and announced his support for a phased-in comprehensive program that sounds much like that proposed by labor leaders and Sen. Edward Kennedy (D-Mass.).

The former Georgia governor, who has been accused by his political enemies of failing to take clear-cut stands on controversial national issues, came out four-square for a broad NHI at the annual convention of the Student National Medical Association.

With Carter's announcement, most of the Democratic Presidential hopefuls are lined up behind federalized NHI, thus assuring that the Democratic Party plank on the issue will come out strongly for such a program.

Carter said he favored universal, mandatory coverage of comprehensive benefits financed through payroll taxes and general tax revenues. He called for strict controls and said NHI should first benefit "those who need it most . . . with the understanding that it will be a comprehensive program in the end."

Declaring "the medical establishment has not responded to the shortages of primary care services and practitioners," Carter said he supports "organized approaches to delivery of services," contending the American health care system has become "a comprehensive catastrophe."

for the inflamed phase of hemorrhoidal flare-up

ANUSOL-HC® SUPPOSITORIES
Rectal Suppositories with Hydrocortisone Acetate

ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate

CAUTION: Federal law prohibits dispensing Anusol-HC Suppositories and Anusol-HC Cream without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian Balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: bismuth subiodide, calcium phosphate, and coloring in a bland hydrogenated oil-cocoa butter base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian Balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, bismuth subiodide, propylparaben, methylparaben, polysorbate 60, sorbitan monostearate in a water-miscible base of mineral oil and glyceryl monostearate. Non-staining

Indications: Anusol-HC is adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis and fissures, incomplete fistulas, and relief of local pain following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. When acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: History of sensitivity to any component. Topical corticosteroids should not be employed in tuberculous, fungal and most viral lesions of the skin (including herpes, vaccinia and varicella).

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy they should not be used unnecessarily on extended areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment. When there is bacterial skin infection, topical corticosteroids should be used only with appropriate concomitant antimicrobial therapy. Prolonged or excessive use of corticosteroids might produce systemic effects.

Dosage and Administration: Anusol-HC Suppositories: Remove foil wrapper and insert into the anus. One suppository in the morning and one at bedtime, for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol.

Anusol-HC Cream: Adults – Remove tube cap and attach the plastic applicator. After gentle bathing and drying of the area, apply to the exterior surface and gently rub in. For internal use, insert the applicator by applying gentle, continuous pressure. Then squeeze tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol.

Supplied: Anusol-HC Suppositories – boxes of 12 (N 0047-0089-12) suppositories in silver foil strips with (WC) printed in black.

Anusol-HC Cream – one-ounce tube (N 0047-0090-01) with plastic applicator, detachable label.

Full information is available on request.

Warner Chilcott
Division,
Warner-Lambert Company,
Morris Plains,
New Jersey 07950

THE PROFESSIONAL SOURCE OF

COMFORT

FOR INTERNAL & EXTERNAL ANORECTAL CONDITIONS

Anusol-HC®

suppositories and cream
with hydrocortisone acetate. Rx only

pain and burning respond in minutes

- without belladonna alkaloids
- without CNS stimulants



Artist's interpretation in bas-relief of external hemorrhoids, postoperative anorectal wounds and anal dermatitis.

Famous Fighters



NEOSPORIN® Ointment
(polymyxin B-bacitracin-neomycin)
is a famous fighter, too.

Provides overlapping, broad-spectrum antibacterial action to help combat infection caused by common susceptible pathogens (including staph and strep).

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

JCAH Presents Quality Assurance Seminars

The Quality Review Center of the JCAH will present more than 40 seminars on quality assurance and patient care evaluation, throughout the country, during the months of May through August.

The primary interest of all JCAH accreditation programs is the quality of patient care. An important function of the survey for accreditation is the requirement for quality assurance activity. Through this series of seminars, the QRC hopes to assist health care professionals in implementing effective quality review programs. Programs are designed to meet the needs of physicians, nurses, administrators, medical records personnel, social workers, hospital attorneys and trustees.

The Joint Commission on Accreditation of Hospitals was incorporated in 1951 with the support of its present member organizations: the American College of Physicians, the American College of Surgeons, the American Hospital Association, and the American Medical Association. JCAH is a nongovernmental, not-for-profit organization with programs for the accreditation of hospitals, long term care facilities, services for the mentally retarded and developmentally disabled, psychiatric facilities, and for ambulatory health care.

G. I. Radiology Course Scheduled

The Department of Radiology and the A. Webb Roberts Center for Continuing Education of The University of Texas Health Science Center are sponsoring a two and one half day course entitled Refresher Course in Gastrointestinal Radiology to be presented Oct. 29-31, 1976, at the Fairmont Hotel in Dallas.

The course meets the criteria for 18 hours of credit in Category I for the Physician's Recognition Award of the American Medical Association. Subject matter will include review of all aspects of gastrointestinal radiology (including ultrasound), with upgrade on latest techniques.

For further information, contact: Robert N. Berk, M.D., Department of Radiology, Parkland Memorial Hospital, 5201 Harry Hines Boulevard, Dallas, TX 75062.

helping you change things for the better

Canton Exchange Bank

A FULL SERVICE BANK

"Your Account Handled in Strict Confidence"

Each depositor insured to $40,000

Branch Offices

Canton East Branch
Bank Of Madison
Bank Of Ridgeland

FDIC

Federal Deposit Insurance Corporation

"Our 95th Year Of Continuous Service"

consider the effect on coexisting glaucoma when you prescribe a vasodilator*



a vasodilator that has not been reported to raise intraocular pressure

VASODILAN®
(ISOXSUPRINE HCl)

TABLETS, 20 mg.

the compatible vasodilator

Mead Johnson LABORATORIES

© 1976 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL-54118

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

DATELINE

Swine Flu Vaccine To Be Given Here

Jackson, MS - The Mississippi State Board of Health is spearheading the program to vaccinate Mississippians against a possible swine flu virus epidemic this winter. Despite some federal funding, the SBH will need assistance from many voluntary groups to achieve its goal of vaccinating 1.9 million people. MSMA has pledged support and assistance for the program as have many other health related, community service and educational organizations.

Med Schools Increase Ethics Training

Chicago, IL - Most of the nation's medical schools are now training their students in medical ethics to enable tomorrow's physicians to better cope with the ethical and moral issues of modern medical care, says a report of a national medical school survey in JAMA. Of 107 medical schools responding to the survey, 97 indicated some kind of medical ethics teaching. More innovative programs crossed faculty lines to include philosophy and theology.

Non-compliance Library Started

Atlantic Highlands, NJ - The Medical Dispenser Company, recognizing the high incidence of non-compliance of a prescribed regimen, has set up a library of articles on this subject. According to George S. Bowden, managing director, physicians will be supplied with copies of the articles on file whenever requested. He requests that any articles published on non-compliance be sent to the library, 174 E. Washington Avenue, Atlantic Highlands, NJ 07716.

Do's and Don'ts of Exercise Listed

Chicago, IL - Do's and don'ts of an exercise program are set forth in a new booklet of the AMA, "Guide to Physicians in Prescribing Exercise Programs." The booklet should be of special use for those patients planning to begin exercising after years of a sedentary life. The fact that an exercise program is only one part of total health care is emphasized and good health practices are listed. Order booklets from AMA, 535 N. Dearborn, Chicago 60610.

AMA-ERF Continues to Grant Loans

Chicago, IL - AMA-ERF granted loans totaling $5,259,800 to 3,737 medical students, interns and residents through the AMA Education and Research Foundation Loan Guarantee Program during 1975, the biggest year for the program since 1966. Since the Loan Guarantee Program started in 1962, AMA-ERF has guaranteed 58,936 loans totaling $69,368,098. AMA-ERF also awarded grants totaling $1,275,000 to U.S. and Canadian medical schools

---

Advanced Cardiac Life Support Course Planned

An Advanced Cardiac Life Support Course will be sponsored by the Mississippi Heart Association during the summer.

Didactic material to be covered in the course includes: advanced life support, adjuncts for airway and breathing, adjuncts for artificial circulation, monitoring and dysrhythmia recognition, defibrillation and synchronized cardioversion, intravenous techniques, essential drugs in emergency cardiac care, useful drugs, acid-base balance, and stabilization and transportation.

Practical material to be presented includes: single and two-person CPR, infant CPR, obstructed airway management, use of airway adjuncts, use of defibrillators, arrhythmia recognition and therapy, IV techniques and pharmacology of drugs used in cardiac emergencies.

Course director is Dr. Alan Tonnesen and faculty are Drs. James F. Arens, Joseph C. Gabel, David Glass, Fred G. Davis, Karl E. Becker, Roderick Malone, and Orin F. Guidry.

it's the real thing

Enjoy Coca-Cola Trade-mark ®

70-37

Mississippi Council of Coca-Cola Bottlers

Requirements are current certification by the American Heart Association in Basic Cardiac Life Support and a commitment to organize Advanced Life Support Training Programs in the participant's local area.

For further information, contact Dr. Tonnesen, Department of Anesthesiology, UMC, 2500 N. State, Jackson, MS 39216 (968-5580) or Peggy McGill, CPR project director, P.O. Box 16063, Jackson, MS 39206 (981-4721).

Governor Appoints Rural Health Advisory Committee

Governor Cliff Finch has appointed Dr. Virginia S. Tolbert of Ruleville to head a committee of family physicians to advise him on the health care needs of rural Mississippi.

Dr. Tolbert asked members of the Mississippi Academy of Family Physicians, representing all areas of the state, to serve on her committee. The committee held an organizational meeting on May 30 at the University Medical Center Alumni House in Jackson.

Those asked to serve on the committee include: Drs. James S. Poole of Gloster, Paul E. Mink of Kosciusko, Donald J. Blackwood of Cleveland, Herbert R. Powers of Vaiden, Edward K. Gore of Houston, Edward Pennington of Ackerman, David M. Segrest of Port Gibson, Walter D. Gunn of Quitman, Thomas N. Braddock of West Point, W. Moncure Dabney of Crystal Springs, James R. Stingley of Hazelhurst, Joseph C. Johnston of Mt. Olive, A. T. Tatum of Petal, Elmo P. Gabbert of Meadville, Dayton E. Whites of Lucedale, John B. Levens, Jr., of Bay St. Louis, and Arthur E. Wood, Jr., of Belzoni.

Others are Drs. Richard T. Furr of Ocean Springs, W. H. Parker of Heidelberg, Prentiss F. Keyes of DeKalb, A. M. McBryde of Sumrall, Frank W. Bowen of Carthage, S. Jay McDuffie of Nettleton, Eugene F. Webb of Itta Bena, Allen P. Durfy, Jr., of Canton, Marion V. Green of Holly Springs, Charles N. Cannon of Philadelphia, Duff D. Austin of Newton, Glen O. Pugh of Brooksville, John T. Copeland of Starkville, William A. Spencer of Sardis, James M. Howell of Picayune, Marshall B. Lynch of Marks, E. L. Whitfield of Florence, Jesse W. Austin of Forest, R. H. Lynch of Rolling Fork, James O. Stephens of Magee, John R. Harper of Taylorsville, Walter R. Rose of Indianola, Gerald A. Smith of Sumner, M. M. Powell, Jr., of Cold-

water, Thomas L. Ketchum of Ripley, Jack M. Senter of Belmont, Thomas K. Chandler of Tunica, Walter W. Crawford of Tylertown, J. Edward Hill of Hollandale, W. W. Walley of Waynesboro, W. A. Brown, Jr., of Mathiston, Jonathan Campbell of Centreville, and Dalton E. Spears of Water Valley.

UMC Can Perform Urinary Metabolic Scans

The biochemical genetics laboratory at the University of Mississippi Medical Center is equipped to perform urinary metabolic scans for state physicians to aid in the diagnosis of metabolic disorders.

Lab director Dr. Fred J. Oelshlegel, Jr., says the lab tests high risk patients—those who show clinical symptoms or who have brothers or sisters with diagnosed disorders or symptoms.

"Detectable metabolic abnormalities occur with a much higher frequency among older infants and children who have unexplained mental retardation, behavioral problems, failure to thrive, developmental retardation, neurological disorders, ophthalmologic disorders such as cataracts or subluxation of lens, hepatomegaly, and unusual odors, especially in the urine," the director said.

In newborns, metabolic abnormalities can lead to unexplained conditions of listlessness, poor appetite, vomiting, diarrhea, hypertonia, hypotonia, acidosis, seizures, unusual physical appearance, and/or unusual odors, he said.

The scan is designed to detect gross increases of many substances such as amino acids and their derivatives, ketoacids, sugars and organic acids. The tests and procedures are qualitative rather than quantitative, he said.

Dr. Oelshlegel said the lab staff prefers 15 ml of an early morning urine specimen. If preservation is necessary, Dr. Oelshlegel suggests a few crystals of thymol.

"If a fresh sample is brought directly to the laboratory no preservation is required," he said.

Because some drugs interfere with test results, the referring physician should also send the patient's recent medication history, in addition to a brief sentence or two as to the reason for referral.

The consult sheet should contain the name of patient, age, sex, race, address, ID number, and the name of the physician to whom the results are to be sent.

Compliments of

The Sheraton-Biloxi Motor Inn

3634 W. Beach—U.S. Hwy. 90

Biloxi, Mississippi 39531

601-388-4141

THE LITTLE CARD THAT'S WORTH $2,000 INSTANT CASH, ANY TIME YOU NEED IT.



Give yourself the security, convenience and emergency protection of one of the world's most exclusive financial services—the American Express Executive Card.

Available at Jackson's warm, friendly, little bank, Fidelity Bank. We also honor Master Charge and BankAmericard.

Fidelity Bank

UTICA/JACKSON, MISSISSIPPI
MEMBER FDIC

The lab is partially supported by the State Board of Health and the Mississippi Regional Medical Program, but a fee is charged for tests performed.

Medical Center Adds to Staff

Four family physicians, including two Mississippi natives, will join the family medicine department faculty at the University of Mississippi Medical Center this summer.

Dr. Ian Cameron will become an assistant professor in June, and Dr. Virgil Issac Aultman, Dr. John F. Hassell, and Dr. Dierdre Melessa Phillips will join the department July 1.

Vice Chancellor Dr. Norman C. Nelson announced the appointments following Board of Trustees of Institutions of Higher Learning approval.

Both Dr. Aultman and Dr. Hassell are graduates of the Mississippi medical school, and Dr. Hassell and Dr. Phillips are completing three-year family medicine residencies at the state institution.

Dr. Cameron, who has been a family medicine practitioner in Fredericton, New Brunswick, since 1970, got his M.D. degree in Dalhousie University School of Medicine, Halifax, Nova Scotia. He interned at Victoria General Hospital, Halifax, and at Victoria Public Hospital, Fredericton. He has also served as a family medicine practitioner at the United Church of Canada, Queen Charlotte Islands Hospital, British Columbia.

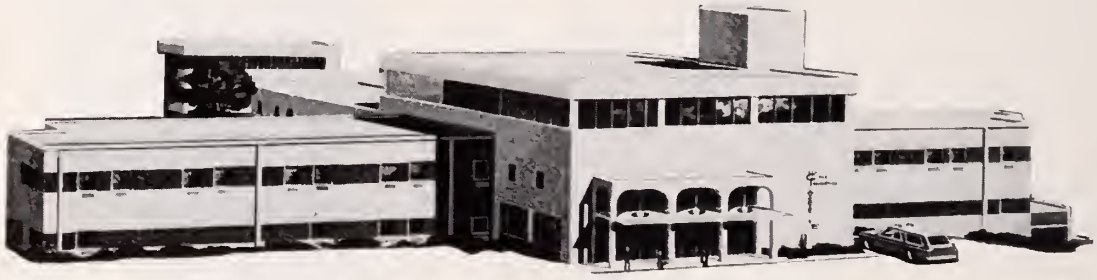
Dr. Aultman, a 1971 graduate of the Mississippi School of Medicine, is coordinator of emergency service and an instructor in family medicine at John Peter Smith Hospital, Ft. Worth, TX, where he interned and did a residency. In the private practice of medicine at Union from July 1972 to June 1973, the Seminary native holds an A.A. degree from Jones County Junior College and is an alumnus of the University of Southern Mississippi.

Dr. Hassell, a Moss Point native, earned his B.S. degree at Mississippi College in 1968 and got his M.D. degree at UMC in 1973.

Dr. Phillips completed her undergraduate work at Newcomb College in New Orleans and received the M.D. degree at Tulane School of Medicine in 1973.

Hill Crest
HOSPITAL
Hill Crest Foundation, Inc.

A non-governmental psychiatric hospital. Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved.
Phone: 205-836-7201



A short-term, intensive treatment center for psychiatric disorders, alcoholism, and drug abuse.

Member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Birmingham Regional Hospital Council.

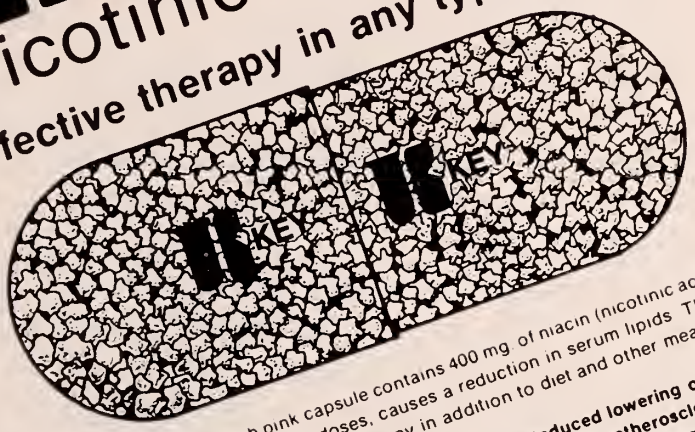
6869 Fifth Avenue South
Birmingham, Alabama 35212

The Original
Slow Release
Form of Nicotinic Acid

nico-Span®

(nicotinic acid) 400 mg. capsules

Effective therapy in any type of drug responsive hyperlipidemia.



DESCRIPTION: Each pink capsule contains 400 mg. of niacin (nicotinic acid) in a special pelletized formulation for prolonged release

ACTIONS: Niacin, in large doses, causes a reduction in serum lipids. The exact mechanism of action is unknown

INDICATIONS: As adjunctive therapy in addition to diet and other measures in the treatment of hypercholesterolemia and hyperbetalipoproteinemia.

Notice: It has not been established whether drug-induced lowering of serum cholesterol or other lipid levels has a detrimental, a beneficial or no effect on the morbidity due to atherosclerosis or coronary heart disease. Several years will be required before current investigations can yield an answer to this question.

CONTRAINDICATIONS: Niacin is contraindicated in patients with hepatic dysfunction or in patients with active acute peptic ulcer.

WARNINGS: The use during pregnancy and lactation or in women of childbearing age requires careful weighing of potential benefits versus possible hazards to the mother and child. There are insufficient studies done for usage in children.

PRECAUTIONS: Patients with diabetes, gall bladder disease, past history of jaundice, liver disease, or peptic ulcer should be observed closely. At initial stage of therapy, liver function and blood glucose should be monitored at frequent intervals. Adjustment of diet and/or hypoglycemic therapy may be necessary. Patients undergoing antihypertensive therapy may experience an added vasodilating effect with resulting postural hypotension. Use with caution in patients predisposed to gout.

ADVERSE REACTIONS: Severe flushing, decreased glucose tolerance, activation of peptic ulcer, abnormal liver function tests, jaundice, gastrointestinal disorders, dry skin, pruritus, hyperuricemia, toxic amblyopia, hypotension, transient headache.

DOSAGE AND ADMINISTRATION: The dose and frequency for the administration of NICO-SPAN should be adjusted to the response of the patient. Slow build-up of dosage in gradual increments is recommended to observe efficacy and/or adverse effects. One or two capsules three times a day is the usual dosage. The maximum daily dosage is 6 grams.

Please arrange to provide starter samples and/or complimentary "Starter" prescription booklets for: **nico-Span®** (nicotinic acid, 400 mg.)

Samples ☐ "Starter" Rx's ☐

Dr. _____ Specialty _____

Street _____

City _____ State _____ Zip _____

Mail to: Key Pharmaceuticals, Inc. 50 N.W. 176th Street, Miami, Florida 33169

KEY PHARMACEUTICALS, INC.
Miami, Florida 33169 (U.S.A.)

NOW outpatient minor surgery carries no deductible requirement.

Blue Cross and Blue Shield of Mississippi recently broadened its hospital minor surgery benefits by eliminating the $25 deductible requirement applicable to such services on its local Basic contracts.

This new benefit, provided at no extra charge to subscribers, is another effort to help relieve the pressure on growing health care costs by encouraging outpatient service where medically justified, instead of the more expensive inpatient services.

There is no substitute for inpatient care when it is necessary, but when the physician determines outpatient services are appropriate, this new benefit goes to work.

Elimination of the $25 deductible requirement for hospital outpatient minor surgery is one more way the Blue Cross and Blue Shield Plan is working to deal with increasing health care costs. If you'd like more information on this new benefit, contact the Customer Services Department or your Professional and Provider Relations Representative.

Working together, we can help contain the rising costs of health care.





Blue Cross®
Blue Shield®
of Mississippi

P. O. Box 1043 / 530 E. Woodrow Wilson Ave. / Jackson, Mississippi 39205 / Tel. 982-0010

* Registered Marks Blue Cross Association
** Registered Service Marks of the National Association of Blue Shield Plans

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
June 1976, Vol. XVII, No. 6

ORIGINAL PAPERS

The Undescended Testis

R. S. HILLIS, M.D. and J. E. KEETON, M.D.
Jackson, Mississippi

There are three forms of testicular maldescent: the true undescended testis, the retractile testis, and the ectopic testis. The extrascrotal testis is less likely to be fertile, has a higher incidence of malignancy, and has a higher incidence of associated inguinal hernia than the normally positioned testis. The extrascrotal testis should be within the scrotum prior to five years of age.

These authors discuss the current knowledge on the pathogenesis, classification, diagnosis and therapy of the undescended testis.

TESTICULAR MALDESCENT is an old and frequently encountered problem. Approximately 2.7 per cent of full term male infants and 21 per cent of premature male infants have failure of descent of one or both testes.[1]

Literally volumes have been written on this subject, often adding confusion to an already confusing array of terms and concepts. It is our purpose in this paper to clarify some of the terminology and to summarize current recommendations for therapy. Controversy still exists in some areas and will exist until properly conducted studies give concepts and theories the backing of scientific data. We feel, however, that our recommendations represent thinking in the "mainstream" of pediatric and urologic therapy and that they are the most reasonable recommendations based on current knowledge.

PATHOGENESIS

The testes develop on the genital ridge of the posterior abdominal wall. Actual descent does not occur until the final two months of gestation which accounts for the high incidence of undescended testis in the premature.

Not all factors responsible for testicular descent are known. It is known that deficient androgenization results in failure of descent. This deficiency may be the result of pituitary insufficiency with deficiency of gonadotrophic hormones, or it may be an end-organ failure in that the testis fails to respond to a normal amount of gonadotrophic stimulation. However, the exact role of androgenic hormones in testicular descent is unknown. It is sufficient to state that they appear necessary for normal testicular descent.

It is also believed that intra-abdominal pressure plays a role in testicular descent. Therefore, males born with absence of the anterior abdominal musculature (so called "Prune-Belly syndrome" or variants thereof) also have failure of testicular descent.

Mechanical impedance to descent is believed to be important, especially in the unilaterally undescended testis. Such a patient may have normal endocrine function and normal muscular anatomy, but one testis is impeded by a mechanical barrier. Occasionally a fibrous septum is identified at the scrotal neck causing the testis to deviate to an ectopic site.

The path of testicular descent includes the internal inguinal ring, the inguinal canal, the external inguin-

From the Division of Urology, Department of Surgery, University of Mississippi Medical Center, Jackson, MS.

al ring and finally the scrotum. The gubernaculum is a band of mesenchyme which appears to connect the scrotum to the testis and pull or guide the testis to the scrotum, but its exact role is unknown. The testis comes from its retroperitoneal position, bringing a fold of peritoneum, the processus vaginalis, the neck of which later obliterates leaving the tunica vaginalis adjacent to the testis.

CLASSIFICATION

Cryptorchism is a non-specific term used to describe all forms of testicular maldescent. It is derived from two Greek words meaning "hidden testis" and, therefore, is lacking in specificity. We consider there to be three forms of testicular maldescent (or cryptorchism): the true undescended testis, the ectopic testis, and the retractile testis.

The true undescended testis is one whose normal descent into the scrotum is interrupted. It lies, therefore, somewhere between its site of origin on the posterior abdominal wall near the kidney and the external inguinal ring. It pursues a normal pathway, but stops short of its goal.

The ectopic testis is one which traverses the inguinal canal normally. However, upon exiting from the external inguinal ring, it pursues an aberrant path and eventually rests at an ectopic site. Such a site may be the perineum, or it may exit from the external ring and fold back to lie anterior to the inguinal canal (the so-called superficial inguinal pouch).

The retractile testis is one which exits from the external inguinal ring and has ample length to lie in the dependent portion of the scrotum. Because of hyperactivity of the cremasteric muscle, it is capable of retracting into the inguinal canal. Such a patient may present to one physician with an empty scrotum and to another with normal appearing intra-scrotal testes.

DIAGNOSIS

Absence of an intrascrotal testis is normally noticed by an examining physician or by an observant parent. Occasionally, the problem can go unnoticed long enough that the patient himself realizes the abnormality. The undescended testis which is fixed in the inguinal canal, at the external inguinal ring, or in the superficial inguinal pouch is particularly vulnerable to trauma since it is immobile, and complaints of pain may bring the patient to the physician.

Physical examination should verify the absence of one or both intrascrotal testis. The inguinal testis or the ectopic testis in the superficial inguinal pouch can often be detected by palpation. The retroperitoneal testis is not palpable unless it has undergone neoplastic change and presents as an abdominal mass. When a young man presents with a large unexplained abdominal mass, the physician should check the scrotum for the possibility of an undescended testis.

The problem in physical diagnosis is differentiating the fixed inguinal testis from the retractile testis. Often a physician must rely on an observant mother and instruct her to put the child in a position to relax the cremasteric muscle. A warm bath will often accomplish this. Serial examinations by the physician may reveal that the testes appear in the scrotum intermittently. If the physician is gentle, he can often apply pressure to the inguinal canal from a lateral to a medial direction, thereby causing the testis to protrude from the external ring. The testis may then be pulled gently to demonstrate that it has adequate length to lie in the scrotum. We do not feel that such a testis needs to be treated.

In addition to establishing the presence or absence of the intrascrotal testis, a complete physical examination should be done with emphasis on examination of the external genitalia since maldescent may be part of a larger problem of sexual differentiation. Even with normal appearing external genitalia, as is usually the case, it is our practice to do a buccal smear to rule out the possibility of intersex. The incidence of urinary tract anomalies is low; therefore, we usually obtain an intravenous pyelogram only in cases of bilateral cryptorchism.

THERAPY

Rationale. It is well documented that the undescended testis loses its capacity for normal spermatogenesis. This is believed to be the effect of normal body temperature on the testis which functions best in the cooler environment of the dependent scrotum. Preservation of fertility is the primary indication for orchiopexy, especially in the case of bilateral cryptorchism.

A second reason for bringing the extrascrotal testis into the scrotum is that the undescended testis has a higher incidence of malignancy. The possibility of malignancy is approximately 35 times greater than in the scrotal testis.[2] Some authors have shown that this propensity to malignant change remains the same even if the testis is brought to the scrotum. Others feel that if the testis is brought down

at an early age that there will be less chance of malignancy than if the testis is left in an extrascrotal position.[3] Even if the potential for malignancy is not changed by orchiopexy, surgery is nevertheless justified since an intrascrotal testis is more easily examined and tumor can be detected earlier than in the extrascrotal testis.

Other reasons for bringing the testis to the scrotum include the increased incidence of torsion and the high incidence of inguinal hernia with the undescended testis. The effect of this abnormality on the emotional development of a child is real and is an important consideration.

Time of Therapy. Spontaneous descent of the undescended testis is common. This is evidenced by the difference in incidence between newborns (2.7 per cent in terms; 21 per cent in prematures) and adults (0.28 per cent in troops undergoing military induction physicals).[4] Spontaneous descent usually occurs during the first 6 weeks of life and rarely occurs after the first year of life. Therapeutic intervention prior to the age of one year would, therefore, be premature since it would be unwarranted in many cases.

Recently, many observers have reported histologic changes in the cryptorchid testis at an early age, and it is currently suggested that treatment should be before age 5 years. Further investigations may show the optimal age for treatment to be even younger. We feel, though, that the older practice of recommending therapy before puberty should be revised and that treatment should be before age 5.

Types of Therapy. (a) *Medical.* There are few carefully controlled studies assessing the effect of medical therapy. Best results have been obtained with injections of human chorionic gonadotrophin (HCG). The patient with bilateral cryptorchism is more likely to respond and the patient with an ectopic testis is not likely to respond at all. HCG may facilitate further descent of the retractile testis, but this probably does not benefit the patient. The only indication for HCG, therefore, is the true undescended testis.

It is recommended that 10,000 units be given. One regimen calls for 20 injections of 500 units each, given three times per week. Another calls for 3 injections of 3,300 units each every other day.

Results of treatment have varied with different authors. Ehrlich, et al, achieved successful descent in 33 per cent of bilateral cryptorchids and 16 per cent in unilateral cryptorchids.[5] Deming reported only 5 per cent overall success, but used a lower dosage.[6]

(b) *Surgical.* We are inclined to favor surgical therapy for the ectopic and true undescended testis. In most cases, location of the testis and careful dissection of the testis and spermatic cord from surrounding structures will afford the surgeon adequate length to place the testis in the scrotum. Rarely, other techniques may be necessary, including bringing the testis medial to the inferior epigastric vessels and creating a new inguinal ring. It has also been shown that additional length may be obtained by completely dividing the spermatic vessels. The testis can survive on the blood supply afforded by small vessels accompanying the vas deferens and when necessary, we have resorted to this with success.

The testis is then secured in the scrotum in normal anatomic position. We prefer a Dartos pouch technique to secure the testis. The testis is placed in a small pouch created between the scrotal skin and the Dartos layer. This technique, as opposed to ones using attachments to the thigh, causes less pain and decreases the duration of hospitalization. Most children can be discharged from the hospital on the first postoperative day.

The anatomic results of surgical orchiopexy are immediately apparent. Functional results are not known until many years later. Longterm follow-up studies by Atkinson show that patients with unilaterally undescended testes who undergo orchiopexy have the same "paternity percentage" as the general population.[7] The patients with bilaterally undescended testes who underwent orchiopexy had paternity percentage approximately one-third less.

SUMMARY

We consider there to be three forms of testicular maldescent: the true undescended testis, the retractile testis, and the ectopic testis. An extrascrotal testis is less likely to be fertile, has a higher incidence of malignancy, and has a higher incidence of associated inguinal hernia than the normally positioned testis. For these reasons, we feel that extrascrotal testes should be placed within the scrotum.

Based on current knowledge, it is our policy to treat these patients between age one and five years. Prior to age one year, spontaneous descent is still possible. After age five years, irreversible damage to the testis begins to occur.

A trial of human chorionic gonadotrophin (HCG) to promote descent is reasonable, but results are not good and are unpredictable. Surgery is usually necessary. We prefer a Dartos pouch type orchiopexy with inguinal herniorraphy. ★★★

2500 North State Street (39216)

REFERENCES

1. Scorer, C. G.: The Descent of the Testis. Arch. Dis. Child. 39:605, 1964.
2. Whitaker, R. H.: Management of the Undescended Testis. Brit. J. Hosp. Med., July, 1970, p. 25.
3. Scorer, C. G. and Farrington, G. H.: Congenital Deformities of the Testis and Epididymis. New York, Appleton-Century-Crofts, 1971, p. 111.
4. Campbell, H. E.: The Incidence of Malignant Growth of the Undescended Testicle: A Reply and Re-Evaluation. J. Urol. 81:663, 1959.
5. Ehrlich, R. M., Dougherty, L. J., Tomashefsky, P. and Lattimer, J. K.: Effect of Gonadotrophin in Cryptorchism. J. Urol. 102:793, 1969.
6. Deming, C.: The Evaluation of Hormonal Therapy in Cryptorchidism. J. Urol. 68:354, 1952.
7. Atkinson, P. M.: A Follow-Up Study of Surgically Treated Cryptorchid Patients. J. Ped. Surg. 10:115, 1975.

THE FIFTY YEAR CLUB

As we look back to our beginning
Fifty years seems but a moment in time
Filled with study, work, hope and pleasure
And a consuming ambition in our prime.

We are the lucky students of mental health,
Able to continue our work today
As we give our best to our patients
And from honesty and truth never stray.

Like wine a good brain improves with age,
Study and research hones the medical mind
For the benefit of those we serve
And the progress and health of all mankind.

Sagacity, judgement, prudence and wisdom
Are qualities of a discerning age,
But not all of us qualify for profundity
At our present physical and mental stage.

Let us all meet here again next year
And as many years after that as we can,
Planning ahead gives purpose to our life
And completes a successful personal plan.

Veronica M. Pennington, M.D.
(Presented before the annual meeting
of the MSMA Fifty Year Club,
May 5, 1976, at Jackson.)

Computerized Axial Tomography

MICHAL A. DOUGLAS, M.D.
Jackson, Mississippi

Computerized axial tomography is a radically new method of neuroradiologic investigation with which every doctor who even occasionally sees neurologic problems should become familiar. The only EMI scanner in Mississippi, now in use at the University Medical Center for six months, is briefly described and a review of the literature is given, along with characteristics of individual lesions which are easily recognized. The practical implications for the present and the prospects for the future are discussed.

It has theoretically been mathematically possible to reconstruct an image from its projections since 1917 when J. Radon, a mathematician, proved that a two or three dimensional object can be reconstructed uniquely from the infinite set of all its projections.[1] Only in recent years, however, has technology become available to put this into practical use. The formidable number of computations involved requires the use of a computer, and new methods of measuring x-ray absorption coefficients are necessary. Oldendorf and Cormick laid the basic groundwork for G. N. Hounsfield in England to develop the first commercial instrument using these principles, called the EMI (Electrical and Music Instruments) scanner. Simply stated, this machine uses a sodium iodide crystal instead of an x-ray film to record the x-ray absorption of a thin beam passed through the head. In any one plane, linear readings are taken 160 times, and repeated at one degree intervals as the machine rotates around the patient's head. From these 28,000 x-ray absorption measurements per plane, the computer uses a mathematical reconstruction technique to approximate that slice of the patient's head. This approximation then can be viewed on an oscilloscope as an array or matrix of light and dark dots or may be printed directly on a sheet of paper with numerical representation of the absorption coefficients. Generally four to five planes in the patient's head are measured this way. Thus one has a look at several tomographic "slices" through the patient's head from approximately the level of the orbit to the top of the skull (see Figure 1a, b, c).

This technique has proven to be extremely sensitive and can detect changes in density inside the skull, such as those caused by tumors, hematomas, abscesses, edema, strokes, and other pathological processes. There have been approximately 60 papers now published documenting the accuracy of diagnosis obtained by this method. Although experience teaches one to view the enthusiasm associated with new techniques cautiously, there is little doubt that this radically new technique will considerably alter neurological, neurosurgical and ophthalmological practice.

From the Department of Neurology, University of Mississippi Medical Center, Jackson, MS.

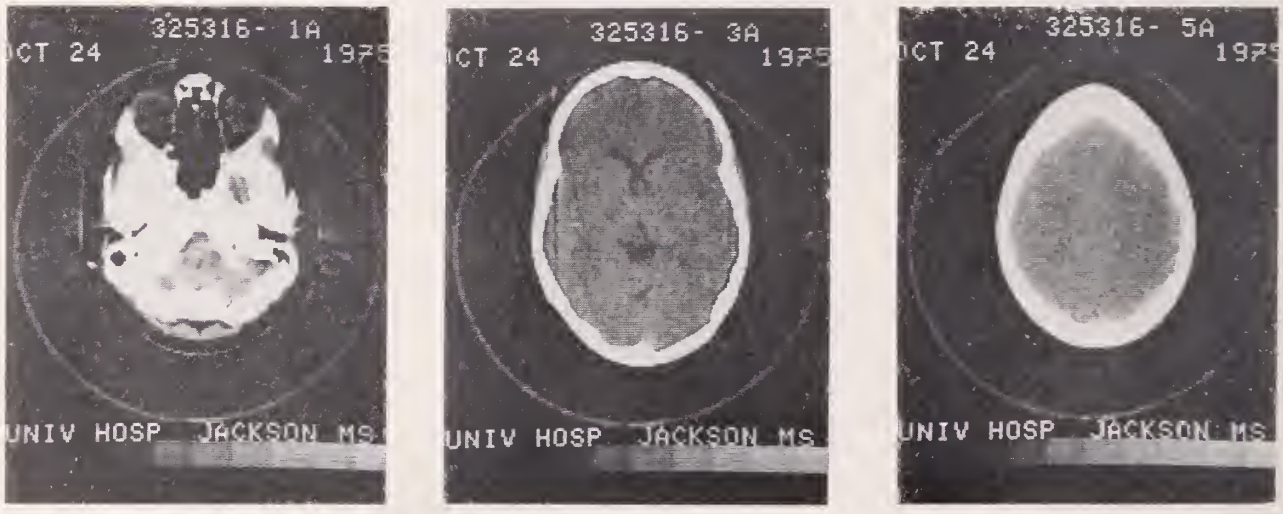
Practically speaking, the examination itself takes about 30 minutes and (being noninvasive) is painless. The patient simply reclines with the top of his head placed into the side of the machine. A water filled balloon (to cut down on artifact in the reconstruction process caused by the contiguity of substances of highly different density) is inflated and wrapped around the top half of the patient's head. Unfortunately, patients with extremely large heads may not fit into the opening and we have had several technical failures because of this. The heads of small children may be pushed out by the water filled balloon. The patient must remain as still as possible during the procedure since any movement causes distortion in the image. With agitated, disoriented or uncooperative patients, and sometimes with small children, sedation may be required.

Since the limit of sensitivity with this technique is the amount of difference in tissue density, any method which enhances that difference will increase the sensitivity. It was appreciated early on that contrast media containing iodine was differentially absorbed by choroid plexus, the dura (slightly), tumors, and other pathological processes. Currently at the University Medical Center selected patients are

given a second CT (computerized tomographic) scan after a dose of intravenous iodinated contrast material (400 mg.). These patients are selected by the radiologist in charge, mainly when a tumor is suspected. The patient is exposed to 1-2.5 R during a routine CT scan, about the same amount of radiation as a routine lateral skull film.

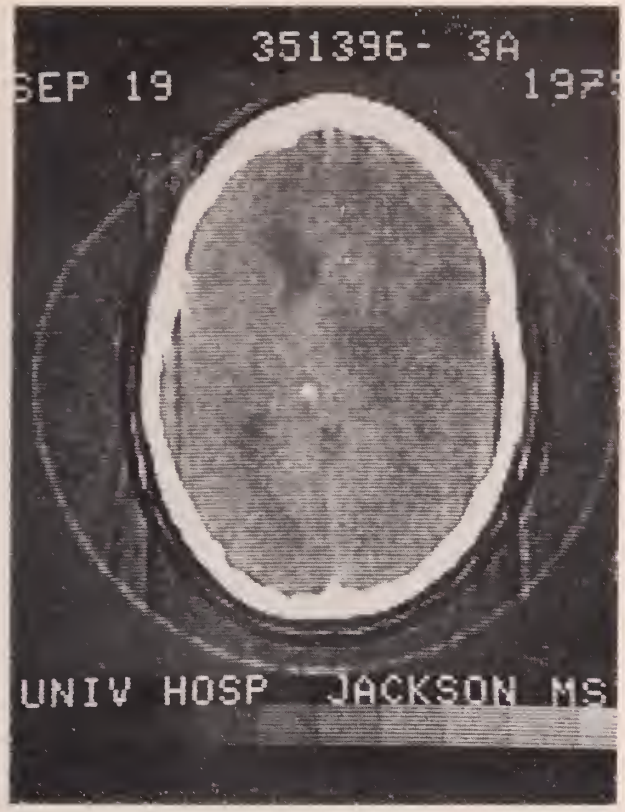
There have now been published three general clinical reviews from different centers which have had CT scanners in use for approximately two years. The first scanner in the U. S. began operation at the Mayo Clinic in 1973. Baker, et al[2] from the Mayo Clinic reviewed their first 800 CT scans and reported 29 combined false positive and false negative results. Some 300 computerized axial tomographic examinations were reviewed and reported by New, et al from the Massachusetts General Hospital.[3] Out of 52 tumors there was only one false negative examination. Paxton and Ambrose[4] from London reported on their first 650 patients in which they had nine false negative examinations involving intracranial tumors. Combining these three studies, the total error is 39 out of 1,750 cases or 2.2 per cent. This estimation of the error is probably excessively high for the following reasons. First, most of these studies were using the 80 × 80 display matrix which has significantly less resolving power than the newer 160 × 160 matrix. Second, many of these errors were in the early use of the machine and in retrospect would no longer be made. Lastly, there was very little contrast enhancement used in these studies. So, eliminating these three factors, the total corrected error for 1,750 patients was nearer 1.4 per cent.

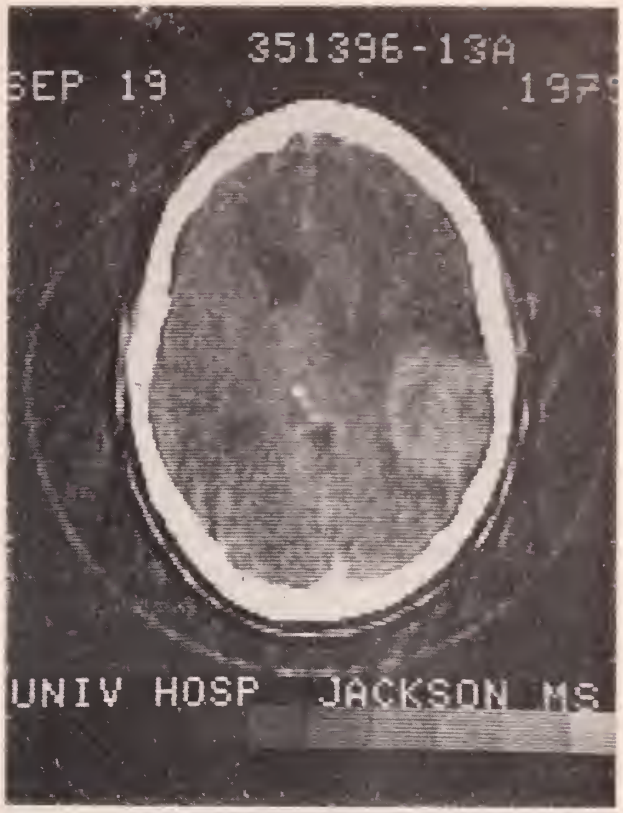
Any lesion which alters the density of the intracranial contents may show up on the CT scan. Almost all varieties of intracranial tumors have thus been identified. Astrocytomas, including glioblastoma multiforme, are usually readily apparent as ill defined areas of either decreased or increased tissue density. The areas of decreased density correspond to areas of necrosis in the tumor while the denser areas correspond to compact tumor cells or blood (see Figure 2a, b). There is often an associated contralateral displacement of the midline structures. Meningiomas usually occur as a high density lesion, often with a large area of surrounding low density which is interpreted as edema (see Figure 3). They also commonly displace the midline structures. Small meningiomas may occasionally be hard to see unless they are directly in the plane of the scan and if not, only their associated edema may be appreciated. They may also be difficult to see if they are in the high convexity of the parietal region where they are obscured by the skull. Cerebral metastases usually have excellent demonstration. They may be either high or low density areas and show a particular propensity to contrast enhancement (see Figure 4a, b). Pituitary adenomas may not be seen on the routine scan, but are usually seen as high density lesions after contrast enhancement. Acoustic neuromas are also readily apparent, but also only after contrast enhancement. Craniopharyngiomas are usually easily distinguishable because of their tendency



a *b* *c*

1. (a) Lower most EMI section through a normal brain. (b) Middle EMI section through a normal brain. (c) Upper most EMI section through a normal brain.

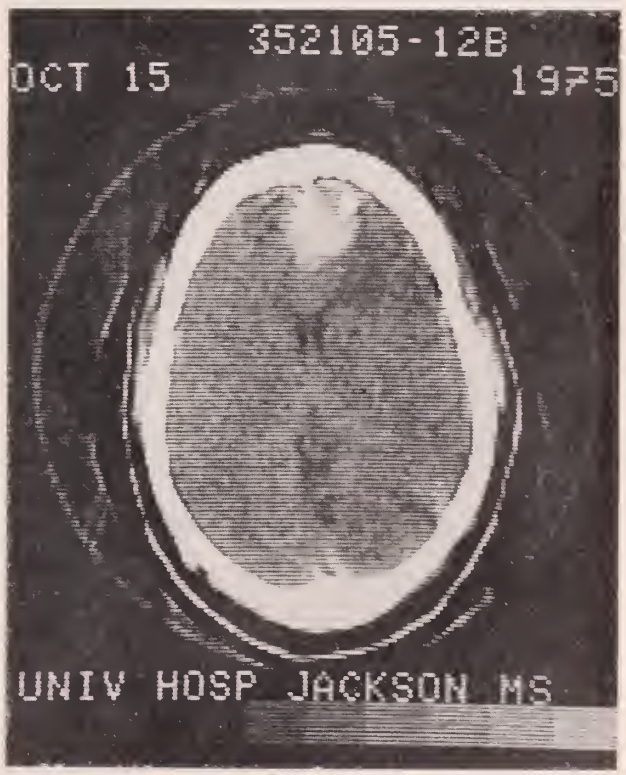




2. (a) Section through a right parietal glioblastoma multiforme, before contrast. Note midline shift of pineal (seen as a bright dot because of calcification), obliteration of right lateral ventricle, edema surrounding a possible mass. (b) With contrast enhancement the tumor itself is outlined.

to contain fat and cystic areas which contrast nicely in the CT scan. Oligodendrogliomas, ependymomas, colloid cysts, chordomas, medulloblastomas, and hemangioblastomas have also been identified. Except for the few characteristics mentioned above, however, it is rarely possible to tell the exact histologic type from the CT. Like the radionuclide scan, the CT scan in cerebral infarction undergoes an evolutionary picture. Early in the course of the infarction, within hours or within the first two to three days, the CT may show no change or only a slight, low density area in the region of infarction (see Figure 5). This may sometimes be detectable only by averaging the absorption coefficients in a given region of suspected insult. However, in seven to ten days the area of necrosis becomes more sharply defined and the lesion is usually clearly discernible. Areas which were involved by edema before this have returned to normal density. However, after three to four weeks when the radionuclide scan has often returned to normal, the CT will continue to show areas of old infarction as sharply defined or irregular areas of low density.

Probably the most easily distinguishable lesion using the CT scan is cerebral hemorrhage (see Fig-

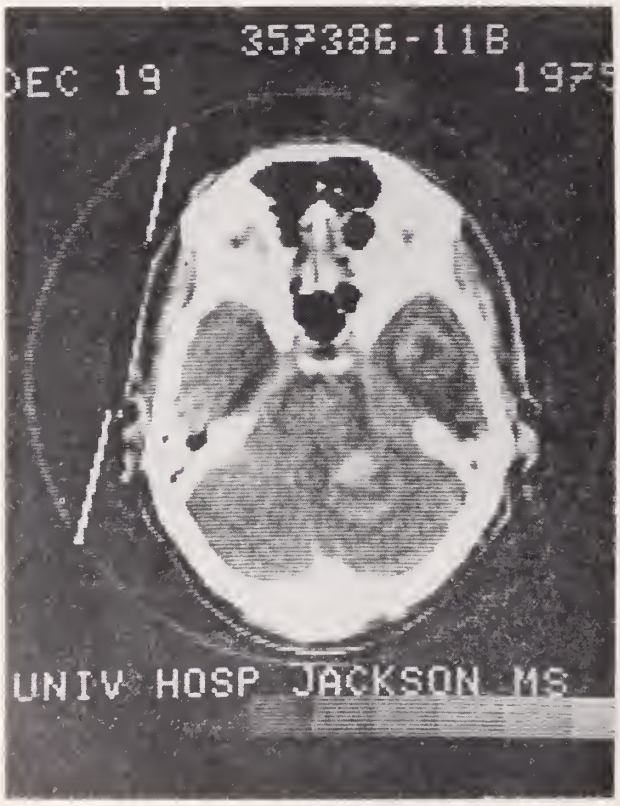


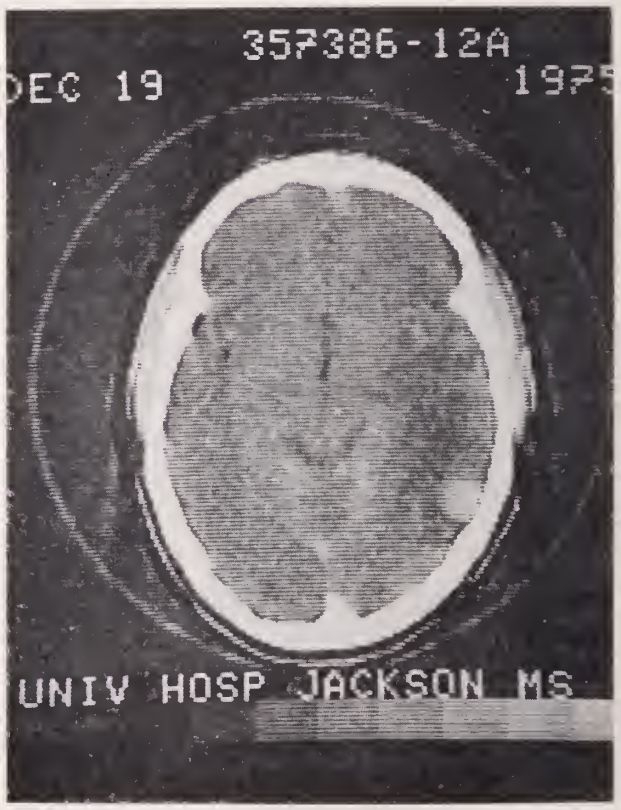
3. (a) A high density frontal mass, found to be a meningioma at surgery.

ure 6). Scott, et al[5] from the Massachusetts General Hospital studied 23 patients with acute intracerebral and/or intraventricular hemorrhage. Because of the consistently and persistently elevated values of extravascular blood there were *no* false negatives or false positives in any case of intracerebral hemorrhage. They also determined that clotting was not necessary for the high absorption values obtained, and concluded that red blood cells are responsible for the elevated absorption values of extravascular blood. The CT scan is the first and only method available for precisely determining the extent of intracerebral hemorrhage during life.

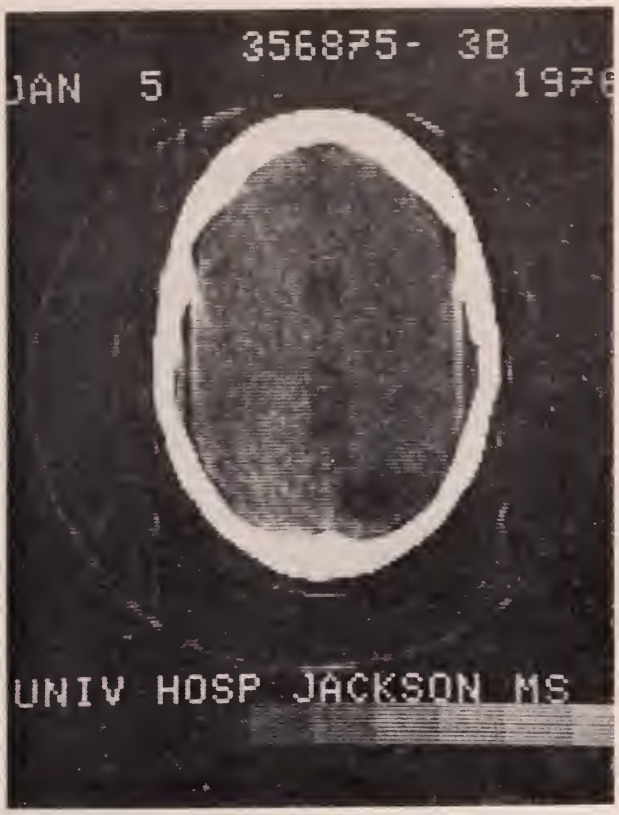
The clinical diagnostic and prognostic information obtainable by computerized axial tomography as discussed above can already be seen to be of invaluable usefulness. In two of Scott's patients the decision to operate was made because of the demonstration of the extreme lateral deviation of the hematoma. The ability to determine the bleeding site in a patient with multiple aneurysms or AVMs guides the surgery to the appropriate site. (AVMs really are only demonstrated when associated with a hematoma). A hemorrhagic infarct vs. a white infarct may be recognized and immediately the appropriate care can be given. It is now being recognized that, contrary to previous thought, intraventricular hemorrhage is not an absolutely ominous prognostic indicator and did not adversely affect the outcome of several patients in Scott's series. Cerebral atrophy and hydrocephalus aiding in the differentiation of the dementias are probably secondary only to intracranial hemorrhage in their ease of demonstration (see Figure 7a, b).

The CT scan with 160 × 160 matrix is also extremely valuable in the diagnosis of orbital space occupying lesions. Ambrose, et al[6] from Atkinson-Morley's Hospital in London reported a preliminary study of 24 patients with suspected orbital tumor and verified the type of lesion present in 17. They saw examples of meningiomas, hemangiomas, neurolemmomas, pseudotumor, orbital melanomas and lacrimal gland tumors. A comparison of the diagnostic accuracy of the CT scan with orbital venography, axial hypocyclodial tomography and ultrasound revealed comparable values of about 75 per cent. A combination of these methods greatly enhances the accuracy of intraorbital diagnosis.





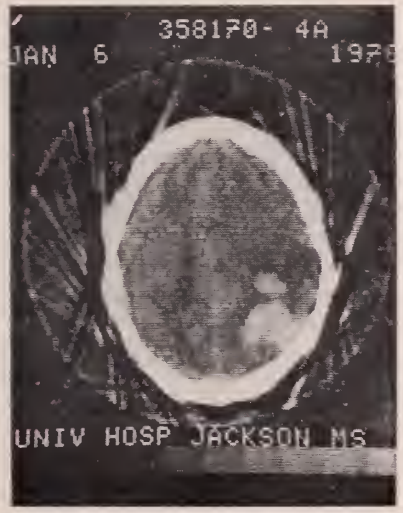
4. (a) Metastatic lesions easily seen after contrast enhancement in right temporal lobe and right cerebellum. (b) Same case, another lesion seen with considerable surrounding edema in right parieto-occipital area.



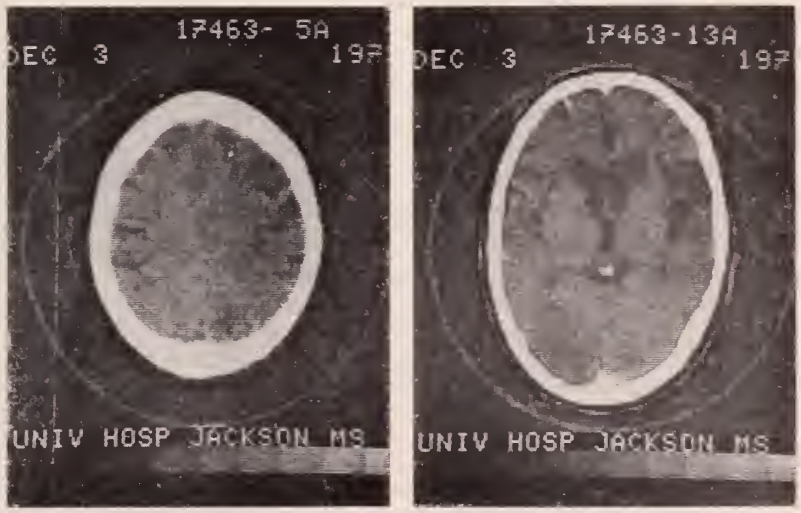
5. (a) Early right occipital infarct.

Impact on Neuroradiologic Practice. The Mayo Clinic has had a CT scanner for approximately two years now and has evaluated its impact on neuroradiologic practice. Mayo's data[7] indicate the total number of arteriograms over that time has decreased 20 per cent, the number of pneumoencephalograms has decreased 40 per cent, and the number of brain scans has also decreased 40 per cent. The CT has not affected the number of EEGs done. The large number of pneumoencephalograms done to evaluate ventricular size and the possibility of cerebral atrophy which are no longer necessary account for the large reduction in pneumoencephalography. The primary indication for pneumoencephalography now is with suspected lesions around the sella turcica or the base of the skull where the high resolution of the pneumoencephalogram is much better than the CT scan. The indications for arteriography have gradually changed. Cerebral arteriography is now rarely used in any sort of screening procedure for convulsive disorders or presenile dementias and is rarely used in evaluation of acute head traumas. The value of the radionuclide scan compared to the CT scan has yet to be determined. Pendergrass, et al[8] from the Massachusetts General Hospital have published one study comparing the two, and concluded that the computerized axial tomographic scan was better than the brain scan in every area. (The two techniques were approximately equal in the demonstration of cerebral infarcts). However this conclusion remains to be fully substantiated by further studies. It is our experience that the "high" uptake of meningiomas on the radionuclide scan often gives a better indication of the histology of this particular lesion than the CT.

Future Prospects. One of the obvious disadvantages of the CT scanner is the necessity for enclosing the head in the water filled container. This difficulty has already been circumvented with the ACTA (automatic computerized transverse axial) tomographic scanner in use at the National Institutes of Health and by the Delta scanner in use at the Cleve-



6. (a) Primary intracerebral hemorrhage.



7. (a) and (b) Cortical atrophy with greatly increased space between cortical sulci; enlarged ventricles are evident.

land Clinic. Any part of the body may be scanned with these machines and preliminary reports[9] have already demonstrated primary and metastatic neoplasms of various organs such as the liver, pancreas, and kidney, pericardial effusions, renal cysts, abdominal aneurysms, gallstones, mediastinal masses and numerous bony abnormalities. It remains to be seen whether or not herniated discs may be seen by this method. Syringomyelia and diastematomyelia are readily diagnosed and this will undoubtedly become the procedure of choice for these diagnoses.[10] Unfortunately, the intracranial views from these total body scanners are at present significantly inferior to those of the present CT scanner. The use of the CT scanner as a screening device, theoretically desirable, will have to await an increased number of facilities. The EMI scanner at UMC is already being used to capacity.

There are two major theoretical limits to the amount of information obtainable from this method. The first is that there is only so much information which can be extracted in the form of a reconstruction from a given dose of x-rays. The second is that as the volume within the patient's body is broken down into smaller and smaller pieces the computing time required becomes prohibitive. Present research now centers on the development of an improved mathematical reconstruction technique and developing even faster computers. ★★★

2500 North State Street (39216)

Acknowledgement: All EMI pictures are courtesy of Dr. William F. Russell, Department of Radiology, University of Mississippi Medical Center, Jackson, MS.

REFERENCES

1. Gorden, R. et al: Image Reconstructions From Projections. Scien. Amer. 233:56-68, Oct. 1975.
2. Baker, H. L. et al: Early Experience With the EMI Scanner for Study of the Brain. Radiology 116:327-333, 1975.
3. New, P. F. J. et al: Computerized Axial Tomography With the EMI Scanner. Radiology 110:109-123, 1974.
4. Paxton, R. and Ambrose, J.: The EMI Scanner, A Brief Review of the First 650 Patients. Br. J. Radiol. 47:530-565, 1974.
5. Scott, W. R. et al: Computerized Axial Tomography of Intracerebral and Intraventricular Hemorrhage. Radiology 112:73-80, 1974.
6. Ambrose, J. et al: A Preliminary Evaluation of Fine Matrix Computerized Axial Tomography (EMI Scan) in the Diagnosis of Orbital Space-Occupying Lesions. Br. J. Radiol. 47:747-751, 1974.
7. Baker, H. L.: The Impact of Computed Tomography on Neuroradiologic Practice. Radiology 116:637-640, 1975.
8. Pendergrass, H. P. et al: Relative Efficacy of Radionuclide Imaging and Computed Tomography of the Brain. Radiology 116:363-366, 1975.
9. Alfidi, R. J. et al: Computed Tomography of the Thorax and Abdomen; a Preliminary Report. Radiology 117:257-264, Nov. 1975.
10. Di Chiro, G. et al: Computerized Axial Tomography in Syringomyelia. NEJM 292(1):13-16, Jan. 2, 1975.

The cost to U.S. taxpayers of emphysema and other chronic respiratory diseases in Social Security disability payments adds up to over $400 million a year. Christmas Seal dollars support research grants, fellowships, faculty positions, and other programs to find out more about lung disease and ways to prevent it. Contact the Mississippi Lung Association, P. O. Box 9865, Jackson, MS 39206 for information.

Counsel to Authors

THE JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, Miss. 39216, in original and at least one duplicate copy. They must be typewritten double spaced on 8½ by 11-inch white bond paper with a standard typewriter.

The author is responsible for all statements made in his work, including changes made by the manuscript editor. Manuscripts are received with the understanding that they are not under simultaneous consideration by any other publication and have not been previously published. All manuscripts will be acknowledged, and while those rejected are generally returned to the author, the JOURNAL is not responsible in event of loss. Manuscripts accepted for publication become the property of the JOURNAL and are copyrighted by the association when published. They may not be published elsewhere without written release and permission from both the JOURNAL and the author.

All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10, but when justified to the Editors, additional references will be considered for publication. Each will be critically examined, and only valid, primary references will be published. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus,* volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made after proof sheets are received by the JOURNAL.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for illustration engravings not exceeding four column inches per printed page.

Illustrations must be numbered and cited in the text. Legends, not exceeding 40 words and preferably shorter, must accompany each illustration, typed double spaced on separate sheets. The following information should appear on a gummed label affixed to the back of each illustration: Figure number, manuscript title, author's name, and arrow indicating top of the illustration.

In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

A thesis summary of 75 to 100 words must accompany each manuscript separately from the text.

Reprints may be obtained at cost plus shipping charges from the association and should be ordered prior to publication. The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. —*The Editors.*



The President Speaking

"Convention in Jackson"

LYNE S. GAMBLE, M.D.
Greenville, Mississippi

A FRIENDLY city, beautiful weather, a well planned and well organized program of excellent scientific presentations, and a hard working House of Delegates combined to make the 108th annual session of the Mississippi State Medical Association an outstanding success. The total recorded attendance was 960, including 503 MSMA members.

Among the honored guests were the genial president of the American Medical Association, Dr. Max H. Parrot, and his attractive wife. Dr. Parrot addressed the House of Delegates and also the luncheon meeting of the Auxiliary. The luncheon meeting of the Mississippi Academy of Family Physicians was addressed by the Honorable Cliff Finch, Governor of Mississippi. It was indeed like old times to hear Dr. Alton Ochsner, consultant in surgery, Ochsner Clinic and Ochsner Foundation Hospital, New Orleans, speak to the Section on Family Practice on Venous Thrombosis: Complications and Prevention. During the week of our convention, Dr. Ochsner was honored in New Orleans on the occasion of his 80th birthday.

The House of Delegates once again vindicated the integrity of the reference committee system. A very well informed panel discussed Public Law 93-641 Monday afternoon. And on Thursday morning the House of Delegates strongly protested the arbitrary and discriminatory manner in which Public Law 93-641 was being implemented by the Mississippi Health Systems Agency, Inc. The House of Delegates also authorized the Board of Trustees or their designated representatives to meet with the governor relative to appointment of positions to the Statewide Health Coordinating Council.

In other action: In an effort to find new approaches to the resolution of the professional liability insurance crisis, the House of Delegates authorized the initiation of an in depth study of the cost and benefits of a patient compensation program for medical injuries similar to the present workman's compensation program.

A resolution authorizing the establishment of a fund to seek legal redress against any plaintiff and/or attorney filing a malpractice suit against a member of the association which appears to have no legal foundation and/or to be filed maliciously was reported unfavorably by the reference committee. The reference committee stated that in their opinion the medical and legal professions should work together to resolve the professional liability crisis. The report of the reference committee was adopted by the House of Delegates.

(Continued on page 163)

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, June 26-July 1, Dallas. Clinical Convention, Dec. 4-8, 1976, Philadelphia. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

La.-Miss. O. and O. Society, April 28-May 1, 1977, Point Clear, Ala. Arthur Hays, M.D., Secy., 3017 13th St., Gulfport 39501.

STATE AND LOCAL

Mississippi Academy of Family Physicians, Annual Meeting, July 7-10, 1976, and July 6-9, 1977, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 109th Annual Session, May 2-5, 1977, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Smith, Yazoo.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Gerald A. Smith, Secy., P.O. Box 128, Sumner 38957. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. A. K. Martinolich, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Reginald P. White, Secy., East Mississippi State Hospital, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, April, June, August, October, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., Jefferson Davis Memorial Hospital, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. D. Stanley Hartness, Jr., Secy., 314 Adams St., Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Lee H. Rogers, Secy., 610 Brunson Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, October. Cherie Friedman, Secy., 1004 Jackson Ave., Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. James H. Sams, Secy., P.O. Box 1381, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, May, July, September, November. Dewey Laner, Secy., Doctors Plaza, Suite 206, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. John L. Smith, Secy., No. 1 Medical Blvd., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

When the same patient makes your office a merry-go-round of somatic complaints



Adapin® (doxepin HCl) may be what she needs

I'm so jumpy, I'm afraid of my own shadow.

I have these headaches almost everyday—I can't understand it, I never used to have them.

Doctor, is it right that I should be so constipated all the time?



Anxiety/depression could be the basis of her somatic complaints
You know the type. She's got a new symptom every visit. And there's never any physiological basis. When you see the chronic "complainer," a diagnosis of depression may be considered . . . and an Rx for Adapin.

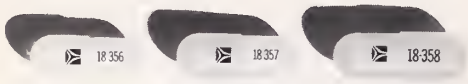
Adapin allays anxiety; improves sleep; brightens the outlook
Adapin can often help the chronic "complainers" get positively reinvolved with life. Adapin almost immediately allays symptoms of anxiety and tension. And from the earliest days it makes it easier for the patient to get to sleep—helps her stay asleep longer. And where there is underlying depression, Adapin usually begins to lift it within three or four weeks.

Please see following page for prescribing information

ADAPIN®
(Doxepin HCl)
Capsules, 10 mg, 25 mg and 50 mg

PENNWALT

ADAPIN®
(Doxepin HCl)



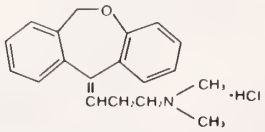
10 mg. **25 mg.** **50 mg.**

Usual optimum dosage is 75 to 150 mg. per day.

Prescribing information:

DESCRIPTION

Adapin (doxepin HCl) is an isomeric mixture of N, N-dimethyl-dibenz(b,e) oxepin- $\Delta^{11(6H)}$, γ propylamine hydrochloride.



ACTIONS

Adapin has a variety of pharmacological actions with its predominant action on the central nervous system. While its mechanism of action is not known, studies have demonstrated that it is neither a monoamine oxidase inhibitor nor a primary stimulant of the central nervous system.

INDICATIONS

In controlled clinical evaluations, **Adapin** has shown marked antianxiety and significant antidepressant effects. **Adapin** has been found to be well tolerated even in elderly patients.

Adapin is indicated for the treatment of patients with:

1. Psychoneurotic anxiety and/or depressive reactions.
2. Mixed symptoms of anxiety and depression.
3. Anxiety and/or depression associated with alcoholism.
4. Anxiety associated with organic disease.
5. Psychotic depressive disorders including involutional depression and manic-depressive reactions.

Target symptoms of psychoneurosis that respond particularly well to **Adapin** include: anxiety, tension, depression, somatic symptoms and concerns, insomnia, guilt, lack of energy, fear, apprehension and worry.

Because **Adapin** provides antidepressant as well as antianxiety effects, it is of particular value in patients in whom anxiety masks depression. Patients who have not responded to other antianxiety or antidepressant drugs may benefit from **Adapin.**

In a large series of patients systematically observed for withdrawal symptoms, none were reported—a finding which is consistent with the virtual absence of euphoria as a side effect and the lack of addictive potential characteristic of this type of chemical compound.

CONTRAINDICATIONS

Because **Adapin** has an anticholinergic effect, it is contraindicated in patients with glaucoma or a tendency toward urinary retention.

Use of **Adapin** is contraindicated in patients who have been found hypersensitive to it.

WARNINGS

Usage in Pregnancy—Adapin has not been evaluated in pregnant patients. Therefore, it should not be used during pregnancy unless, in the judgment of the physician, it is essential to the welfare of the patient.

In animal reproduction studies of **Adapin,** gross and microscopic examination of the offspring gave no evidence of drug-related teratogenic effect. Following doses of up to 25 mg./kg./day for 8 to 9 months, no changes were observed in the number of live births, litter size, or lactation. A decreased rate of conception was observed when male rats were given 25 mg./kg./day for prolonged periods—an effect which has occurred with other psychotropic drugs and has been attributed to drug effect on the central and/or autonomic nervous systems.

Usage in Children—The use of **Adapin** in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors—Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with **Adapin.** The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

PRECAUTIONS

Drowsiness may occur with **Adapin (doxepin HCl);** therefore, patients should be warned of its possible occurrence and cautioned against driving a motor vehicle or operating hazardous machinery while taking the drug.

Patients should also be cautioned that the effects of alcoholic beverages may be increased.

Since suicide is an inherent risk in depressed patients and remains a risk through the initial phases of improvement, depressed patients should be closely supervised.

Although **Adapin** has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Compounds structurally related to **Adapin** can block the effects of guanethidine and similarly acting compounds. However, at the usual clinical dosages, 75 mg. to 150 mg. per day, **Adapin** has been given concomitantly with guanethidine without blocking its antihypertensive effect. But at dosages of 300 mg. per day or higher, **Adapin** has exerted a significant blocking effect.

Adapin, like other structurally related psychotropic drugs, potentiates norepinephrine response in animals. But this effect has not been observed with **Adapin** in humans, which is in accord with the low incidence of tachycardia reported clinically.

ADVERSE REACTIONS

Anticholinergic Effects: Dry mouth, blurred vision and constipation have been reported. These are usually mild, and often subside as therapy is continued or dosage reduced.

Central Nervous System Effects: Drowsiness has been observed. It usually occurs early in the course of therapy and tends to subside as therapy continues. (See Dosage and Administration section.)

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported adverse effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects (such as increased sweating), weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

DOSAGE AND ADMINISTRATION

In most patients with mild to moderate anxiety and/or depression: 10 mg. to 25 mg. t.i.d. to start. A starting dosage of 10 mg. t.i.d. for a period of four days may reduce the initial drowsiness experienced by some patients, and may be tried in cases where drowsiness is clinically undesirable. Decrease or increase the dosage at appropriate intervals according to individual response. Usual optimum dosage is 75 mg. to 150 mg. per day.

In some patients with mild symptomatology or emotional symptoms accompanying organic disease, dosage as low as 25 mg. to 50 mg. per day has provided effective control.

In more severe anxiety and/or depression: 50 mg. t.i.d. may be required to start—if necessary, gradually increase to 300 mg. per day. Additional effectiveness is rarely obtained by exceeding 300 mg. per day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

OVERDOSAGE

Symptoms—An increase of any of the reported adverse reactions, primarily excessive sedation and anticholinergic effects such as blurred vision and dry mouth. Other effects may be: pronounced tachycardia, hypotension and extrapyramidal symptoms.

Treatment—Essentially symptomatic; supportive therapy in the case of hypotension and excessive sedation.

HOW SUPPLIED

Each capsule contains doxepin, as the hydrochloride: 10 mg. (NDC 0018-0356), 25 mg. (NDC 0018-0357) and 50 mg. (NDC 0018-0358) capsules in bottles of 100, and 1000.

Brighter days ahead for your psychosomatic complainers



PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XVII, NUMBER 6
JUNE 1976

EDITORIALS

Thoughts on Annual Session

The recent meeting of the MSMA was in my opinion a great success. Attendance was above any previous meeting to my knowledge. The technical exhibitors were well pleased with the visits of those attending and the scientific exhibits were exceptionally good. The scientific sessions were well attended and some very interesting papers were presented.

The president of the AMA gave an enlightening talk and our own able president presented his address in his usual capable manner and gave a "state of the union" report and timely suggestions for action by the body.

It is always a little disconcerting to this writer to hear those who seldom or never attend ask what was done about some question of their concern. They have seldom or never mentioned those problems prior to the annual session.

Let us all be reminded that ours is a democratic organization and that each member can have input by talking to their delegates prior to these sessions. The general assembly is open to all the membership and while they cannot vote or speak to the assembly without unanimous consent of that body, all resolutions are presented to the assembly in its first session and each resolution is referred to an appropriate reference committee where all are welcome and each who so desires will be heard.

Our concerns and problems pertain more and more to socioeconomic matters. These affect the lives and practices of all members. Times are rapidly changing and with further intervention of government into our lives and practices, it becomes increasingly necessary that we all participate in planning or protest.

Rest assured that if we don't help decide our destiny we can only expect that it will be determined by others with or without our approval.

Let's all participate.

W. Moncure Dabney, M.D.
Editor
Crystal Springs, MS

The President Speaking

(Continued)

The scientific exhibits were of excellent quality and gave evidence of many hours of hard work. Unfortunately the physical layout of the available space would not permit them to have the prominence which they deserved. The technical exhibits were also of excellent quality and as usual contributed to the success of our meeting. The Bicentennial Party was a sell out. It was indeed an hilarious occasion, and everyone enjoyed the Gas Light Road Show.

As I begin serving as your president, I do so with deep humility and a profound awareness of the critical times we face. The responsibilities of this office would be overwhelming were it not for the faith I have in the support and unselfish loyalty of every member of our association. As we enter this new year, it is apparent that there are several areas in which serious problems could develop. I solicit your consideration, advice, and assistance in solving these problems as they arise. ★★★

POSTGRADUATE CALENDAR

June 3-4, 1976
TRAUMA TRAINING FOR PHYSICIANS
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Departments of Surgery and Anesthesiology and the University Medical Center Division of Continuing Health Professional Education

Coordinators:
William A. Neely, M.D., professor of surgery, the University of Mississippi School of Medicine
Joseph C. Gabel, M.D., associate professor of anesthesiology, the University of Mississippi School of Medicine

This course is a symposium on the management of the trauma patient. Current approaches to the immediate resuscitation of the trauma patient as well as new concepts in subsequent management will be emphasized. Advance registration is requested for the course, open to all physicians; fee is $50.

June 17, 1976
EARLY DETECTION OF HEAD AND NECK CANCER: A MULTIDISCIPLINARY APPROACH
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Nursing, the University Medical Center Division of Continuing Health Professional Education, and the National Cancer Institute Project for Head and Neck Cancer in cooperation with the American Cancer Society, Mississippi Division, Inc.

Coordinator:
Dale E. Clark, M.M.S., coordinator, Head and Neck Cancer Network, the University of Mississippi Medical Center

Open to physicians, dentists, RNs, LPNs, dental hygienists, and dental auxiliaries, this session is the first in a planned series to give health professionals new information about head and neck cancer, with emphasis on early detection, coordinated treatment, and total rehabilitation. Program objectives are to identify, field test, and evaluate available and new methods in a limited number of communities for the detection, diagnosis, staging, treatment, and rehabilitation of patients with head and neck cancer. Supportive data collected will be used to determine the program's practicality and acceptability prior to dissemination into the wider cancer control community programs. Course fee is $10.

FUTURE CALENDAR

September 16-17, 1976
GENETICS COURSE

October 4-8
FAMILY MEDICINE REVIEW

October 11-15
EKG INTENSIVE COURSE

October 25-29
HEMATOLOGY/ONCOLOGY INTENSIVE COURSE

November 8-12
NEPHROLOGY INTENSIVE COURSE

November 15-17
UROLOGY INTENSIVE COURSE

December 2-3
INFECTIOUS DISEASES INTENSIVE COURSE

May 2-5, 1977
MISSISSIPPI STATE MEDICAL ASSOCIATION, BILOXI

The University of Mississippi Medical Center Division of Continuing Health Professional Education offers intensive refresher courses to meet physicians' clinical practice needs in the specialties most requested. Mississippi Regional Medical Program partially supports the series, open to all physicians. Intensive courses are eligible for AMA Physician Recognition Award Category I credit. Enrollment is limited, and applications are accepted in the order received. All correspondence about intensive and other courses should be addressed to Continuing Health Professional Education, University Medical Center, 2500 North State Street, Jackson, MS 39216.

THE LITERATURE

Book Review

Current Medical Diagnosis & Treatment—1976. By Marcus A. Krupp, M.D., and Milton J. Chatton, M.D., 1062 pages. Los Altos: Lange Medical Publications, 1976. $14.00.

Revised annually since 1962, *Current Diagnosis & Treatment* has become quite popular with practicing physicians as well as with residents and medical students. In recent years it has become *Current Medical Diagnosis & Treatment* as companion works for pediatrics and surgery have been published. The 1976 edition is printed in seven languages, including Serbo-Croatian (?).

The popularity of the book is easy to understand. Like all Lange publications, it is inexpensive, paperback, and easily portable—too big, however, for the pocket of a lab coat. Its fund of information is enormous, and for the most part accurate and current.

Discussions of many disorders begin with "Essentials of Diagnosis," which are concise and full of pearls. Some of the very best discussions are those on carcinoma of the breast, cardiovascular drugs, and diabetes mellitus. On the other hand, the section on chronic renal failure is notoriously weak.

Several special features deserve mention. The appendix contains not only tables of normal values but such useful items as a list of schedules of controlled drugs and a set of medical recommendations for foreign travel. At the end of the chapter on Skin and Appendages is a list of 52 commonly used topical preparations. There is an excellent set of instructions on care of the feet for diabetics. One feature conspicuous by its absence was a unified discussion of ultrasound, especially echocardiography.

In summary, the book is an excellent source of current information and well worth the investment. I would not suggest that one should buy each yearly new edition, but after a lapse of several years it is like discovering an old friend who is changing with the times.

BRUCE ATKINSON, M.D.
Amory, MS

NEW MEMBERS

BECKER, KARL E., Jackson. Born Atchison, KA, Aug. 29, 1943; M.D., Johns Hopkins University, Baltimore, MD, 1969; interned Massachusetts General Hospital, Boston, MA, one year; anesthesiology residency, same, one year; anesthesiology residency, University of California, San Francisco, CA, one year; elected by Central Medical Society.

BRANTLEY, NAN, Jackson. Born Jackson, MS, May 28, 1929; M.D., University of Mississippi School of Medicine, Jackson, 1973; psychiatry residency, same, Jan. 1973-Dec. 1975; elected by Central Medical Society.

CLAY, JOSEPH V. F., JR., Whitfield. Born Philadelphia, PA, Oct. 7, 1911; M.D., Hahnemann Medical College of Philadelphia, PA, 1939; interned, same, one year; elected by Central Medical Society.

DRAPER, EDGAR, Jackson. Born St. Louis, MO, Feb. 5, 1926; M.D., Washington University School of Medicine, St. Louis, 1953; interned City Hospital, St. Louis, one year; psychiatry residency, University of Cincinnati, Cincinnati, Ohio, 1954-55 and 1957-59; Elected by Central Medical Society.

FIESELMAN, DAVID W., Jackson. Born Sequin, TX, Oct. 29, 1941; M.D., Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, NC, 1967; interned University Medical Center, Jackson, MS, one year; pathology residency, Tulane and Charity Hospital, New Orleans, LA, 1971-74; elected by Central Medical Society.

GARNER, MABEL T., Fayette. Born Sharon, MS, June 11, 1931; M.D., Meharry Medical College School of Medicine, Nashville, TN, 1959; interned Hubbard Hospital, Nashville, one year; elected by Homochitto-Valley Medical Society.

KELLY, ROY A., JR., Jackson. Born Baton Rouge, LA, April 26, 1941; M.D., Louisiana State University School of Medicine, New Orleans, 1967; in-

terned Charity Hospital, New Orleans, one year; urology residency, Martin Army Hospital, Ft. Benning, GA, Sept. 1970-June 1971; urology residency, Tripler Army Medical Center, Honolulu, Hawaii, July 1971-June 1974; elected by Central Medical Society.

KNUTSON, RICHARD A., Greenville. Born Schenectady, NY, Feb. 10, 1937; M.D., New York Medical College, New York, NY, 1970; interned Metropolitan Hospital Center, New York City, one year; surgery residency, New Rochelle Hospital, NY, one year; orthopaedic surgery, same, 1972-75; elected by Delta Medical Society.

MALONE, WILLIAM J., Columbus AFB. (Associate) Born Auburn, NY, Oct. 19, 1946; M.D., State University of New York Medical Center, Stony Brook, NY, 1972; interned Wilmington Medical Center, Wilmington, DL, one year; pediatric residency, same, 1973-75; elected by Prairie Medical Society.

MCGEHEE, HELEN G., Waveland. Born Des Moines, IA, Oct. 5, 1935; M.D., University of Texas Medical Branch, Galveston, TX, 1959; interned Baptist Memorial Hospital, Houston, TX, one year; elected by Coast Counties Medical Society.

MILES, BETTY C., Jackson. Born Bruce, MS, Jan. 29, 1948; M.D., University of Mississippi, Jackson, 1972; interned, same, one year; anesthesiology residency, same, 1973-76; elected by Central Medical Society.

SCALLORN, GLENDA J., Jackson. Born Tupelo, MS, Mar. 10, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1970; interned, same, one year; psychiatry residency, Vanderbilt Medical Center, Nashville, TN, 1971-75; elected by Central Medical Society.

THOMAS, DAVID R., Starkville. Born Jackson, MS, April 26, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned, same, one year; medicine residency, same, 1972-75; elected by Prairie Medical Society.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

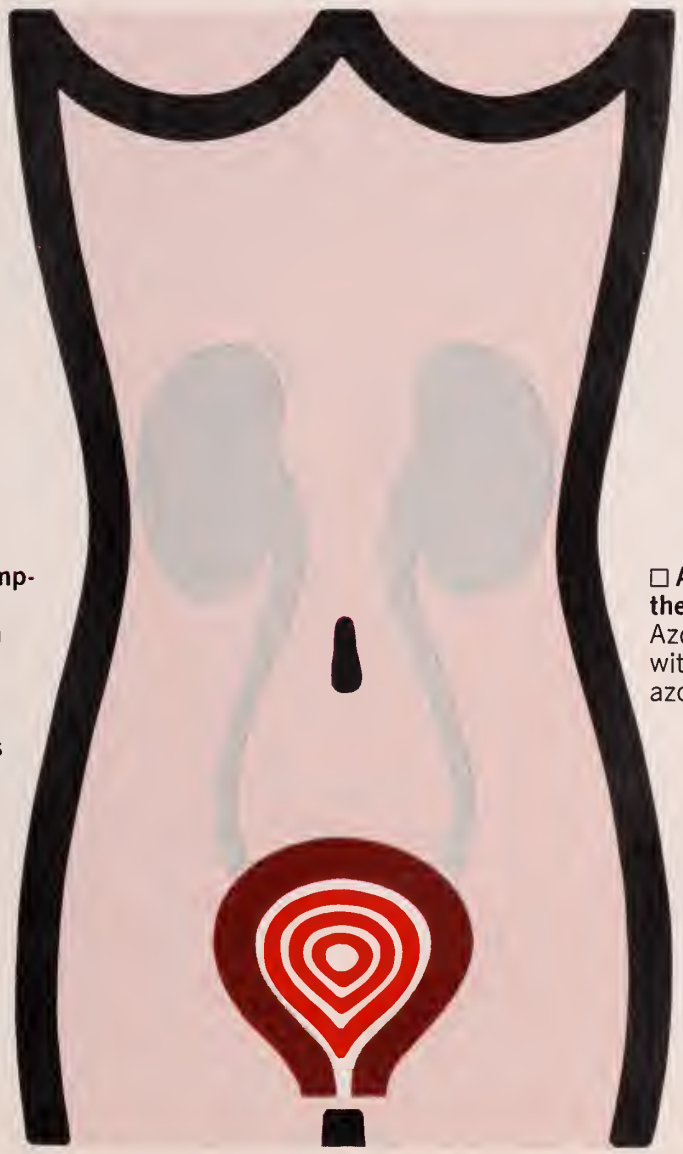
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

When pain complicates acute cystitis*

Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

for the pain for the pathogens



☐ **Early relief of painful symptoms** such as burning and discomfort associated with urgency and frequency.

☐ **Effective control of susceptible pathogens** such as *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris.*

☐ **Appropriate antibacterial therapy:** up to three days with Azo Gantanol, then 11 days with Gantanol® (sulfamethoxazole).

*nonobstructed; due to susceptible organisms

ROCHE

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

FOR LONG-TERM CONTROL OF HYPERTENSION*

Serum K^+ and BUN should be checked periodically. (See Warnings Section.)



Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Warning
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F Co., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

Upjohn

The Upjohn Company, Kalamazoo, Michigan 49001

Medrol® 4 mg Dosepak*

methylprednisolone, Upjohn

The explicit printed dosage instructions that accompany each Dosepak make it easy for the patient to understand and follow the dosage regimen.



*Trademark



Big Balanced Rock, Chiricahua Mountains, Arizona (approx 1,000 tons)

□ Found useful in the management of vertigo* associated with diseases affecting the vestibular system.
□ Can relieve nausea and vomiting often associated with vertigo.*
□ Usual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.
□ Also available as Antivert (meclizine HCl) 12.5 mg. scored tablets, for dosage convenience and flexibility.
□ Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for nausea, vomiting and dizziness associated with motion sickness.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

PERSONALS

GEORGE ARRINGTON, JR., and ROBERT J. CATER of the Meridian Ear, Nose and Throat Clinic, P.A., announce their relocation of offices to 1516 23rd Avenue.

S. L. BAILEY of Kosciusko announces the association of ROBERT P. FULLER for the general practice of medicine at Bailey Clinic, Highway 12 West.

WILLIAM O. BARNETT of Jackson and UMC addressed the Chattanooga Surgical Academy during April.

JOHN BOWER of Jackson and UMC was a guest speaker at the 115th annual session of the Medical Association of Alabama in Montgomery. His topic was dialysis and transplantation: economic and social implications.

Holmes County Community Hospital has initiated a fund drive to raise $100,000 for installation of an intensive care unit which will be named in honor of PAUL B. BRUMBY, Lexington physician.

WILLIAM J. BURNETT of Oxford, KENNETH N. REED and MICHAEL E. JABALEY of Jackson were guest speakers at the Clarksdale and Six Counties Medical Society scientific session.

ROBERT L. DONALD, JR., of Pascagoula was among the nominees for Jackson County's outstanding young men award.

JAMES "JIMBO" GREEN of Meridian was inducted into the University of Southern Mississippi Sports Hall of Fame during the 12th annual Awards Dinner on May 8.

GEORGE C. HAMILTON, JR., of Jackson is new chief of staff of Riverside Hospital in Jackson. Other officers are S. RAY PATE, vice president, and ANTHONY J. SANTANGELO, secretary. Appointed as the clinical committee for 1976 were MARIO PINEDA, BARBARA GOFF, NAN BRANTLEY and WILLIAM C. MCQUINN.

L. GERALD HOPKINS of Oxford served as chairman of the committee to organize May as High Blood Pressure Month in Mississippi. Dr. Hopkins is also president-elect of the Mississippi Heart Association.

MICHAEL E. JABALEY of Jackson and UMC spoke on head and neck surgery at the Society of Air Force Clinical Surgeons meeting at Keesler Air Force Base and presented a paper on "applications of the karapandzic principle of lip reconstruction following excision of lip cancer" at the Joint Society of Head and Neck Surgeons/American Society for Head and Neck Surgery meeting in San Diego.

RONALD R. LUBRITZ of Hattiesburg and KENNETH E. POWELL and WILLIAM B. WILSON of Jackson are new fellows of the American College of Physicians.

DEWEY LANE of Pascagoula became the 27th president of the Mississippi Economic Council at the organization's annual meeting in Jackson during April.

W. H. MERRELL of Jackson has been appointed to the advisory board of St. Dominic-Jackson Memorial Hospital.

FRANCIS S. MORRISON of Jackson and UMC was a participant in discussion of regionalization in blood banking and the functional regional criteria as this relates to the provision of adequate volunteer blood at the American Blood Commission annual meeting.

JOE R. NORMAN and JOSEPH C. GABEL of Jackson and UMC participated in a study on current problems in intensive care at the University of California School of Medicine, San Francisco.

W. T. OAKES of Amory received the Physician of the Year award at the recent state convention of the National Association of Medical Assistants.

RICHARD RILEY of Meridian and JOHN CLAY of Jackson have taped a television program, "Prevention and Treatment of Cancer," under the direction of the Lauderdale County chapter of the American Cancer Society. The show was aired on WTOK-TV, channel 11.

JAMES H. SAMS of Columbus participated in the 80th annual Boston Marathon.

JOSEPH G. SPRINGER, JR., has associated with the Coastal Medical Center, P.A., Gateway Executive Park in Biloxi for the practice of family medicine.

New officers of Clarksdale and Six Counties Medical Society are president, WALTER TAYLOR of Clarksdale; president-elect, JOE CAMPBELL of Clarksdale; and secretary-treasurer, GERALD SMITH of Sumner.

WILL THOMPSON of Yazoo City has been named a trustee of King's Daughters Hospital.

RAUL E. VALENZUELA of Jackson and UMC presented a paper, "Retinal Fat Emboli," at the Inter-

national Symposium on Fluorescein Angiography in Brussels, Belgium.

W. L. WALDRON of Jackson received a plaque in appreciation of his service as chief of staff of Riverside Hospital for the years 1973-75.

W. LAMAR WEEMS of Jackson and UMC chaired the committee on education and science during the American Urological Association southeastern section meeting in Hollywood, FL.

TERRY E. WESTBROOK announces the opening of his office for the practice of family medicine at 612 Delaware Avenue in McComb.

JOHN KNOX WILSON announces the relocation of his medical offices for general practice to 112 Jeff Davis Avenue in Long Beach.

DEATHS

JARRETT, GUY C., Vicksburg. Born Brownsville, TN, April 7, 1900; M.D., University of Tennessee College of Medicine, Memphis, 1927; interned John Gaston Hospital, Memphis, one year; pediatrics residency, Children's Memorial Hospital, Chicago, IL, one year; died April 17, 1976, age 76.

Fast Food Fare Gets Good Calorie Rating

The fast food fare of children and adolescents—cheeseburger, French-fried potatoes and milkshake—is a fairly good meal from the nutritional standpoint, says a report in the April issue of the *American Journal of Diseases of Children.* Laurence Fineberg, M.D., pediatrician at Montefiore Hospital and Medical Center, Bronx, N. Y., made a study of calorie, vitamin and mineral content of the typical teenager menu.

This menu adds up to about 4,100 calories, too high for sedentary adults but only about 10 per cent higher than the intake for the average U. S. male adolescent, says Dr. Fineberg. Protein, carbohydrate and fat is provided, and the fat is lower than might be expected. Virtually all of the vitamins and minerals are there too. A couple of glasses of whole milk daily and some leafy vegetables once a day would make up the difference. And a daily glass of fruit juice would be a good extra, he says.

BRIEF SUMMARY OF
PRESCRIBING INFORMATION
ANTIMINTH® (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017



eliminates Pinworms and Roundworms with a single dose

- **Single dose effectiveness against both pinworms and roundworms**—The only single-dose anthelmintic effective against pinworms *and* roundworms.
- **Nonstaining**—to oral mucosa, stomach contents, stools, clothing or linen.
- **Well tolerated**—the most frequently encountered adverse reactions are related to the gastrointestinal tract.
- **Economical**—a single prescription will treat the whole family.
- **Highly acceptable**—pleasant-tasting caramel flavor.
- **Convenient**—just 1 tsp. for every 50 lbs. of body weight. May be taken without regard to meals or time of day.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Please see prescribing information on facing page. NSN 6505-00-148-6967

Antiminth® ORAL SUSPENSION
(pyrantel pamoate) equivalent to 50mg pyrantel/ml

Mississippi Thoracic Society Elects Officers



The Mississippi Thoracic Society honored outgoing president, Dr. John R. Williams of Greenville (left) during the Thoracic Society Meeting-Pulmonary Seminar at the University Medical Center in Jackson. Dr. Walter Treadwell, newly-elected MTS president, and Dr. G. Boyd Shaw, American Thoracic Society councilor, both of Jackson, presented the Past-President's Certificate to Dr. Williams during the one-day session designed for continuing medical education on "Acute Pulmonary Medicine." Other newly elected MTS officers are: Dr. Richard Furr of Ocean Springs, vice-president, and Dr. Joe Norman of Jackson, secretary-treasurer.

Physicians Still Lead Public Confidence Polls

When a political candidate emerges the winner despite potent opposition from special-interest groups and the press, there is a standard way of describing his success:

"He had everybody against him but the people."

Today that could reliably be said of physicians. The polls show doctors are retaining their public esteem, regardless of onslaughts from various denizens of Capitol Hill, regulatory agencies, Ralph Nader, Max W. Fine, and the *New York Times*.

According to a new survey by Louis Harris, the people view physicians more favorably than all other sources of their health care.

Topping the 15 categories surveyed are medical specialists, viewed favorably by 83 per cent of the public and unfavorably by only 9 per cent. Confidence in general practitioners has risen from 72 per cent favorable-19 per cent unfavorable in 1968 to 81 per cent-16 per cent.

Hospitals in general got a 70 per cent favorable-27 per cent unfavorable rating in the poll, which was conducted for the Federation of American Hospitals.

Private, nonprofit hospitals received a 60 per cent favorable-21 per cent unfavorable rating, compared with 53 per cent-20 per cent for military and veterans' hospitals.

Physicians were rated the most trustworthy of occupations in a survey by Chilton Research Services. In another survey, more than 8 of 10 people interviewed by Roper Reports said they were "very satisfied" or "fairly well satisfied" with both the quality and availability of their medical care. While a majority considered medical costs too high, 8 of 10 expressed satisfaction with their provisions for meeting those costs.

Medico-Legal Briefs

BOTH HOSPITAL AND SURGEON LIABLE FOR NURSES' NEGLIGENCE

Both a hospital and a surgeon were liable for the negligence of nurses in taking a sponge count during an operation, a Texas appellate court ruled.

Claiming damages for leaving a lap sponge in her abdomen following surgery, a patient sued the surgeon and the hospital. A jury found that the physician was not negligent in failing to see the sponge in her abdomen before closing and that the failure of the assisting nurses to make a correct lap pack count caused the injury. The jury awarded the patient $21,644.90 against the hospital only.

On appeal, the court said that the surgeon had such control over the nurses in the operating room as to render him liable for the negligence under the "captain of the ship" doctrine. This conclusion did not preclude a finding that the hospital was also liable, since the nurses were employed, paid and instructed by the hospital, the court said. The nurses were legally the servants of both the hospital and the surgeon, the court observed.

The jury was properly instructed that the nurses had to meet the standard of care which a person of ordinary prudence would meet. Finally, the surgeon's statement to a nurse that "we are in trouble" when he told her that a sponge had been left in the patient was not admissible as a conclusion of liability, the court said.

The trial court's verdict against the hospital was affirmed and its verdict in favor of the surgeon was reversed.—*Worley Hospital, Inc. v. Caldwell,* 529 S.W.2d 639 (Tex. Ct. of Civil App., Oct. 31, 1975; rehearings denied, Nov. 24, 1975)

Dr. Lyne S. Gamble Is Inaugurated President, Dr. James O. Gilmore Is Named President-elect

Dr. James O. Gilmore of Oxford was named president-elect of the association at the closing meeting of the 108th Annual Session, and Dr. Lyne S. Gamble of Greenville was inaugurated 1976-77 president, succeeding Dr. Jack A. Atkinson of Brookhaven.

The four-day meet was headquartered at the Holiday Inn Downtown and featured meetings of the nine scientific sections, meetings of more than 15 specialty societies, and medical alumni and social occasions. More than 30 essayists presented a varied program which drew praise of registrants. Some of the scientific presentations will be published in future issues of the JOURNAL.

The Jackson session had a record high registration of 960 which included 503 members, 22 physician guests, 2 interns, 36 residents, 15 medical students, and 67 guests (non-physician). Others included 161 exhibitors, 142 Auxiliary members and 12 staff.

Handling a heavy business agenda, the House of Delegates acted on 18 reports, 6 of which were from the Board of Trustees, and 10 resolutions. Three reference committees conducted hearings before which members and guests appeared for discussion and debate. On Monday afternoon there was a special panel discussion on the national Health Planning and Resources Development Act.

Dr. Jack Atkinson addressed the opening meeting of the House of Delegates on May 3 on the federal government's increasing involvement in health care, continuing education as a requirement for MSMA membership, the need for more primary care physicians, and called for a public awareness campaign in regard to the professional liability crisis. The



Three years of the association's presidency are represented by, from left, Dr. Jack A. Atkinson of Brookhaven, immediate past president, 1975-76; Dr. Lyne S. Gamble of Greenville, newly inaugurated MSMA president, 1976-77; and Dr. James O. Gilmore of Oxford, the new president-elect, 1977-78.



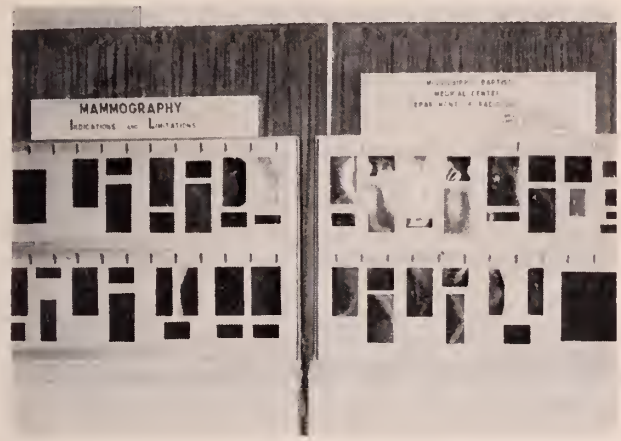
The 1975-76 MSMA president, Dr. Jack A. Atkinson, addresses the opening session of the House of Delegates and gives his "state of the union" report. The president's address will be published in the July 1976 issue of the JOURNAL MSMA.

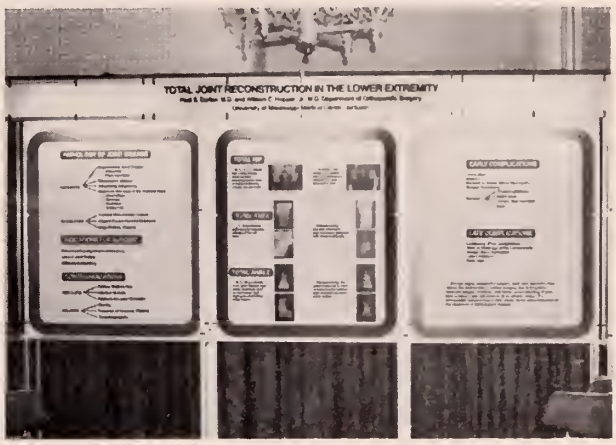


Shown above are officers of MSMA and the component societies who enjoyed their first annual breakfast meeting to discuss the relationship of the association to the component societies. Below at left is shown Dr. Lamar Weems of Jackson, chairman of the Council on Constitution and By-Laws, as he makes his report to the House of Delegates. At right is Dr. Everett Crawford, chairman of the Reference Committee on Reports of Officers, Councils, and Board of Trustees.





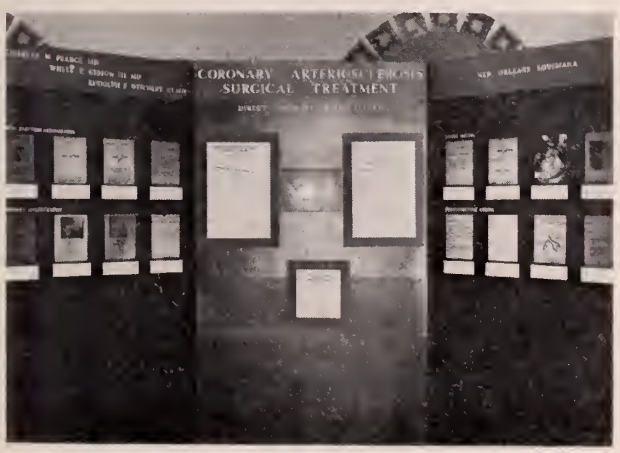




Winners of the awards for best scientific exhibits are shown. Top left, "Mammography," by Drs. Elmer J. Harris, James M. Packer, and Robert P. Henderson of the Mississippi Baptist Medical Center in Jackson received the first prize Aesculapius Award, an engraved walnut plaque, for best exhibit by members of the association. Top right, "Total Joint Reconstruction in the Lower Extremity," by Drs. Paul S. Derian and W. C. Hopper of the University Medical Center in Jackson received the second place award in the member category. Lower left is "Coronary Arteriosclerosis—Surgical Treatment," by Drs. Charles W. Pearce, White E. Gibson and Rudolph Weichert of New Orleans, winner of the Scientific Achievement Award, a sculptured bronze medallion, in recognition of the best presentation by a non-member. Lower right is shown "Fiberoptic Endoscopy—Colonoscopy, Esophagoscopy and Gastroduodenoscopy," by Drs. Jack B. Campbell, Edward M. Lowicki and Charles E. Farmer of Jackson, which received an honorable mention. In the inserts at right are shown, top, Dr. James P. Spell, chairman of the MSMA Council on Scientific Assembly, presenting the first place award to Dr. James M. Packer; and second place winners Dr. W. C. Hopper and Dr. Paul S. Derian displaying their engraved walnut plaque.











Preceding the reference committee meetings on Monday, May 3, was a special panel discussion on the national Health Planning and Resources Development Act.



Members of the reference committees were briefed on their duties during a breakfast meeting on May 3. Speaker C. D. Taylor of Pass Christian and Vice Speaker Faser Triplett of Jackson conducted the session.



The Council on Constitution and By-Laws debated the resolutions and reports referred to it with interested members of the association present.



The Reference Committee on Reports of Officers, Councils, and Board of Trustees also heard members speak on the various reports and resolutions referred to it.

1975-76 president urged Mississippi physicians "to continue to be responsive to the public's concern and desire for quality health care at a reasonable cost."

Sharing the rostrum spotlight with Dr. Atkinson was Dr. Max Parrott of Portland, Oregon, president of the American Medical Association, who discussed the new positivism of the AMA, the coming convention of a National Commission on the Cost of Medical Care, the AMA's landmark lawsuits in federal court against the Utilization Review rules and MAC, and the formation of a reinsurance company to provide a second layer of protection for state societies that sponsor malpractice insurance.

The AMA president emphasized that "the AMA acts as federation of identifiable individuals . . . because its policy is openly set by delegates elected at the state and county levels."

A gift of $11,945.61 was made to the University Medical Center by the state association and the MSMA Auxiliary AMA-ERF campaign.

Vice presidents named to serve during 1976-77 are Drs. J. Edward Hill of Hollandale for the northern area, Hardy B. Woodbridge, Jr., of Jackson for the midstate area, and Brantley B. Pace of Monticello for the southern area.

Dr. W. Moncure Dabney of Crystal Springs was re-elected editor of the JOURNAL MSMA and Dr. George H. Martin of Vicksburg was named to another term as associate editor.

Dr. Joseph B. Rogers of Biloxi was re-elected as delegate to AMA and Dr. James V. Ferguson of Greenwood was elected to a two-year term as alternate delegate to AMA.

Delegates, tallied at 115 in the May 6 balloting, elected Dr. John R. Lovelace of Batesville as trustee for District 2. Re-elected to the Board were Drs. Robert S. Caldwell of Tupelo (District 3) and Whitman B. Johnson of Clarksdale (District 1).

Elected to the Council on Budget and Finance were Drs. William C. Gates, Jr., of Columbus and Sidney O. Graves of Natchez.

New Secretary-Treasurer of the association is Dr. J. Elmer Nix of Jackson. During his three-year term, he will also serve as chairman of the Council on Scientific Assembly, which oversees the annual session.

Dr. Mary J. Ward of Corinth was re-elected to the Council on Constitution and By-Laws, and Drs. W. Richard Campbell of Columbia, David R. Steckler of Natchez and Dewey H. Lane of Pascagoula were named to the Judicial Council.

Drs. Ed Pennington of Ackerman and George L.

108th Annual Session, May 3-6, 1976

DELEGATES ACT ON MAJOR ISSUES AT JACKSON

The House of Delegates at the 108th Annual Session of the Mississippi State Medical Association handled a busy agenda of 18 reports and 10 resolutions. The official "Transactions" of the meeting will be published in the August issue of the JOURNAL MSMA.

Hearings were conducted by reference committees before which discussion and debate were heard on Monday, May 3. Also featured on Monday was a panel discussion of Public Law 93-641, the National Health Planning and Resources Development Act. The reference committees reported to the House on Thursday, May 6, where final action on all reports and resolutions took place.

Among major actions by the House of Delegates were approval of reports and resolutions which:

- Strongly protested the discriminatory and arbitrary manner in which the Mississippi Health Systems Agency, Inc., is presently attempting to implement Public Law 93-641 and instructed the Board of Trustees or its designees to meet with Governor Finch concerning implementation of the law in Mississippi and to investigate the legality of how the law is presently being implemented.

- Called for an extensive campaign to communicate the professional liability insurance crisis to the public financed by a special assessment from the membership.

- Supported the State Board of Health in conducting a swine flu vaccination program but called for more study on the use of the vaccine for pregnant women.

- Ordered an indepth study of the costs and benefits of a patient-compensation program for medical injuries similar to the workmen's compensation program and instructed the Delegates to the American Medical Association to present a similar motion to that body.

- Lifted automatic loss of membership in MSMA for any physician "who voluntarily surrenders his federal narcotics stamp and places himself in a rehabilitation program recommended by that committee of physicians composed under the Mississippi Disabled Physician Act of 1975."

- Presented the 1976 Robins Award for Community Service to Dr. Thomas G. Barnes, Greenville surgeon.

- Asked the Council on Medical Education to present a detailed plan to establish continuing medical education as a condition for MSMA membership for consideration at the 109th Annual Session.

In other actions, the House of Delegates:

- Established new MSMA scientific sections on psychiatry, dermatology and pathology.

- Received a report about incorporation of the "Mississippi Medical Fraternal and Educational Society" as a "captive" professional liability insurance program and noted that the Board of Trustees will keep the membership apprised of the progress and need for such a program in Mississippi.

- Reaffirmed opposition to legislation which would authorize optometrists to diagnose and to use drugs.

- Urged, that at the request of the Vice Chancellor of the University of Mississippi Medical Center, the association support the needs of the Medical Center in working to improve health care in Mississippi.

- Presented check to University of Mississippi School of Medicine in the amount of $11,945.61 representing 1975 contributions to the school from Mississippi physicians and their wives and medical alumni.

- Directed the Board of Trustees to study a recommendation that the House of Delegates convene on Sunday afternoon and that all reports of the board and councils be sent to Delegates two weeks prior to the annual session.

- Confirmed continued alternation of annual sessions of the association between Jackson and the Gulf coast and set the 1980 annual session for May 5-8, in Jackson.

- Supported efforts to give increased attention in the selection process for medical students to applicants from rural areas and supported rural preceptorships and other mechanisms to give medical students an experience with rural practice.

- Commended formation of a statewide Committee on High Risk Maternal and Newborn Care.

- Directed reactivation of the MSMA Committee on Blood and Blood Banking with broad geographic and specialty representation to study current legislative and other activities in this area of interest.

The Reference Committee on Credentials reported seating 120 delegates on May 3 and 115 delegates on May 6.

Serving as reference committee chairmen were Drs. Everett Crawford of Tylertown, Reports of Officers, Councils and Board of Trustees; Stanley A. Hill of Corinth, Rules and Order of Business; and W. Lamar Weems of Jackson, Council on Constitution and By-Laws.

109th Annual Session, May 2-5, 1977, at Biloxi— Mark Your Calendar Now!



The MSMA Auxiliary met during May 2-5 for the 52nd annual session. New officers are, seated from left, Mrs. W. A. Brown of Mathiston, president; Mrs. William Hilbun of Meridian, president-elect; standing from left, Mrs. Sam Rowlett of Vicksburg, first vice president; Mrs. Jim C. Barnett of Brookhaven, second vice president; Mrs. Lee H. Rogers of Tupelo, third vice president; Mrs. John Estess of Hollandale, fourth vice president; and Mrs. W. Moncure Dabney of Crystal Springs, treasurer.

Arrington, Jr., of Meridian were re-elected to the Council on Legislation and Dr. Calvin T. Hull of Jackson is a new member on the council.

The Council on Medical Education was expanded to include a representative from each of the nine association districts. Elected to the council and serving staggered terms are Drs. Whitman B. Johnson of Clarksdale, M. Beckett Howorth, Jr., of Oxford, David B. Ellis of New Albany, James E. Booth of Eupora, Carl G. Evers of Jackson, William M. Hilbun of Meridian, W. Boyce White of Laurel, William E. Godfrey of Natchez, and Karl B. Horn of Pascagoula.

Elected to the Council on Medical Service were Drs. Joseph C. Hillman of Brookhaven, Larry H. Day of Hattiesburg, and Charles N. Floyd of Gulfport.

The four-day annual meeting was approved for 12 hours of credit toward continuing education requirements of the American Academy of Family Physicians and the AMA's Physician Recognition Award.

Mrs. W. A. Brown, Jr., of Mathiston was inaugurated president of the Auxiliary in their concurrent annual meeting. Actions taken at the General Assembly included a name change to Mississippi State Medical Association Auxiliary, a $2.00 dues increase and provision for junior membership for spouses of medical students, interns and residents.

Other Auxiliary officers are Mesdames William Hilbun of Meridian, president-elect; Sam Rowlett of Vicksburg, first vice president; J. C. Barnett, Jr., of Brookhaven, second vice president; Lee H. Rogers of Tupelo, third vice president; John Estess of Hollandale, fourth vice president; and W. Moncure Dabney of Crystal Springs, treasurer.



Members of the Fifty Year Club participated in their annual luncheon meeting during the annual session. Club "officers" are Board chairman, Dr. James O. Gilmore, and MSMA Membership Director Barbara Shelton, who serves as secretary.



Past presidents of the association enjoy a fraternal and traditional breakfast with special guests, Drs. Atkinson and Gamble, candidates for the select circle. Immediate past president, Dr. J. T. Davis of Corinth, was host.



Members of the House of Delegates mark ballots to elect new officers of the association.

Board of Trustees Names 1976-77 Officers

A new name appears on the roster of the association's governing body, the Board of Trustees. Elected by the House of Delegates was Dr. John R. Lovelace of Batesville, representing District 2. He replaces Dr. James O. Gilmore who retired after serving the mandatory number of years on the Board.

Dr. Whitman B. Johnson of Clarksdale was re-elected trustee of District 1 and Dr. Robert S. Caldwell of Tupelo was named to another term representing District 3.

Dr. Caldwell was elected chairman of the board and Dr. Arthur Derrick of Durant, District 4, was elected vice chairman. Dr. Gerald P. Gable, District 7, was named to another year of service as secretary. The chairman, vice chairman and secretary make up the Executive Committee.



Two Greenville physicians received special honors during the annual session. Dr. Lyne S. Gamble, left, new MSMA president, congratulates Dr. Thomas Barnes, winner of the 1976 Robins Award for community service.

Continuing to serve on the Board are Drs. Carl G. Evers and Max Pharr of Jackson, District 5; Joe S. Covington of Meridian, District 6; Sidney O. Graves of Natchez, District 8; Paul H. Moore of Pascagoula, District 9; Lyne S. Gamble of Greenville, president; and Jack A. Atkinson of Brookhaven, immediate past president.

Six general officers meet with the Board: president-elect, secretary-treasurer, speaker of the House of Delegates, vice speaker and the two AMA delegates.

Scientific Assembly Begins Work for '77

The 1977 Annual Session is set for May 2-5, 1977, at the Sheraton-Biloxi. The Council on Scientific Assembly has already begun planning for the 109th.

Acting by separate sections during the recent 108th Annual Session, the nine components of the Scientific Assembly named new chairmen and four sections elected new secretaries. In addition, three new sections, psychiatry, pathology and dermatology, were approved by the House of Delegates.

Under the By-Laws, a section chairman serves a term of only one year, but section secretaries are elected for three years to provide continuity. Secretaries of the sections are elected on staggered terms.

Each office carries an automatic seat and vote in the House of Delegates to assure proper representation of each scientific specialty.

Named to head the Section on Anesthesiology is Dr. Marion P. Parker of Jackson. Dr. Katherine Aldridge of Hattiesburg enters the last year of her



Dr. Lyne S. Gamble is administered the official oath of office by Board chairman James O. Gilmore. Executive Secretary Charles L. Mathews holds the historic association Bible.

three-year term as secretary.

Dr. J. George Smith of Jackson will chair the Section on EENT and new section secretary is Dr. W. J. Burnett of Oxford.

Heading the Section on Family Practice is Dr. John M. Estess of Hollandale. Dr. Hardy B. Woodbridge of Jackson enters the third year of his term as secretary.

The internists chose Dr. Quinton H. Dickerson of Jackson as chairman of the Section on Medicine. New section secretary is Dr. Don Q. Mitchell of Jackson.



Dr. Jack A. Atkinson, 1975-76 president, transfers the official MSMA President's Pin to the lapel of incoming president, Dr. Lyne S. Gamble of Greenville.

Dr. Calvin Hull of Jackson heads the Section on Obstetrics and Gynecology. Secretary Dr. Wadie Abraham of Meridian enters the second year of his term of office.

Dr. Robert L. Abney of Jackson is the new chairman of the Section on Pediatrics. New section secretary is Dr. Robert H. Thompson of Jackson.

Dr. C. Earl Fox of Tupelo will chair the Section on Preventive Medicine. Entering the second year of his term as section secretary is Dr. W. E. Riecken, Jr., of Jackson.

New chairman for the Section on Surgery is Dr. Henry B. Tyler of Jackson. Beginning a three-year stint as secretary is Dr. Jerry R. Adkins of Biloxi.

Heading the Section on Radiology is Dr. Charles A. Ray of Meridian and secretary Dr. Bernard Blumenthal of Jackson enters the second year of his term.

Chairing the new Section on Psychiatry will be Dr. Barbara Goff of Jackson. Secretary for the section is Dr. Glen Anderson of Brandon.

Representing the pathologists will be chairman Dr. Ben F. Martin of Columbus and secretary Dr. William B. Wilson of Jackson.

The dermatologists chose as chairman Dr. Louis J. Wise of Jackson and as secretary Dr. John A. Marascalco of Greenville.

Dr. J. Elmer Nix of Jackson, association secretary-treasurer, is constitutional chairman of the Council on Scientific Assembly. He said that the council will be meeting early this summer to review preliminary plans for the 109th Annual Session and to begin actively working on the program.

The exhibit prospectus for technical exhibitors will be released this fall. Specialty societies are invited to submit plans for concurrent meetings and



Dr. Atkinson is presented the James Grant Thompson Memorial Past President's Pin by Mrs. Thompson of Jackson during the closing moments of the House of Delegates.

requests for assignments of rooms, including those for meal occasions, he added.

The president, Dr. Lyne S. Gamble of Greenville, and the president-elect, Dr. James O. Gilmore of Oxford, are *ex officio* members of the council.

Specialty Societies Hold Concurrent Meetings

A total of 16 specialty societies and related groups met concurrently with the association during the 108th Annual Session at the Holiday Inn Downtown. Scientific sessions and social occasions drew members of almost every specialty.

Psychiatrists from throughout the state attended the May 2 luncheon meeting of the Mississippi Psychiatric Association. Officers are president, Dr. Barbara Goff of Jackson; president-elect, Dr. James E. Ruff of Jackson; secretary, Dr. Glen Anderson of Brandon; and treasurer, Dr. Mary Hogan of Whitfield.

A special postgraduate urology seminar for family physicians was presented on Sunday, May 2, by the Mississippi Urological Society. The society also held a business meeting and luncheon on Monday, May 3. Dr. Gerald Wessler of Gulfport was elected president and Dr. William C. Gates of Columbus, who continues to serve as secretary-treasurer, was named president-elect of the group.



The Mississippi chapter of the American College of Surgeons met during the annual session. New president, Dr. Thomas Barnes of Greenville, at left, is congratulated by outgoing president, Dr. Richard Clark of Hattiesburg.



Officers of the Mississippi Orthopedic Society are, from left, Drs. Cleveland Johnson of Laurel, president; J. Elmer Nix of Jackson, president-elect; Wayne Lamar of Oxford, vice president; Hugh P. Brown of Jackson, secretary-treasurer; and Sidney Berry of Jackson, outgoing president.



Officers of the Mississippi Urological Society are, from left, Drs. William C. Gates of Columbus, president-elect and secretary-treasurer; and Gerald Wessler of Gulfport, president.

The Mississippi Association of Pathologists held a business meeting on Sunday and a scientific session and luncheon on Monday. Officers are president, Dr. Ben F. Martin of Columbus; president-elect, Dr. Roland F. Samson of Jackson; secretary, Dr. William B. Wilson of Jackson; and treasurer, Dr. Allen M. Read of Natchez.

The Mississippi Society of Anesthesiologists met on Sunday, May 2, for a business meeting, the MSMA Section on Anesthesiology, and a dinner. Dr. Marion P. Parker of Jackson was elected president and new secretary-treasurer is Dr. David I. Carlson of Jackson.

The Mississippi Dermatological Society sponsored a seminar for practicing physicians on Monday, May 3. Officers are president, Dr. Louis J. Wise of Jackson; president-elect, Dr. Ronald R. Lubritz of Hattiesburg; and secretary-treasurer, Dr. John A. Marascalco of Greenville.

Orthopedic surgeons convened on May 3 for a scientific meeting and luncheon. New officers are: president, Dr. Cleveland Johnson of Laurel; president-elect, Dr. J. Elmer Nix of Jackson; vice president, Dr. Wayne T. Lamar of Oxford; and secretary-treasurer, Dr. Hugh P. Brown of Jackson.

The Academy of Facial Plastic and Reconstructive Surgery held an organizational meeting on Tuesday,



Officers and members of the Mississippi Dermatological Society presented a dermatological seminar during the annual session. Shown from left are: Drs. Ronald Lubritz of Hattiesburg, president-elect; Louis Wise of Jackson, president; and James McQueen of Jackson. Standing from left are: Drs. W. R. Clement of Gulfport; Tom Garrott of Biloxi; Donald Barraza of Natchez; W. E. Eggerton of Meridian; and James H. Melvin of Jackson.



Officers of the Mississippi Ob-Gyn Society are, from left, Drs. Lewis Lipscomb of Jackson, secretary-treasurer; Lamar Gillespie of Hattiesburg, vice president; Richard Hollis of Amory, president; and Kenneth Pittman of Jackson, president-elect.

May 4, which included a fraternal breakfast and scientific program. Elected officers were president, Dr. Larry H. Day of Hattiesburg; vice president, Dr. Kenneth N. Reed of Jackson; and corresponding secretary, Dr. J. George Smith, of Jackson.

The Mississippi chapter of the American College of Surgeons convened on May 4 for a luncheon, scientific session and business meeting. New officers are Dr. Thomas G. Barnes of Greenville, president; Dr. John R. Lovelace of Batesville, president-elect;



New officers of the Academy of Facial Plastic and Reconstructive Surgery are, from left, Drs. Larry Day of Hattiesburg, president; Kenneth Reed of Jackson, vice president; and J. George Smith of Jackson, corresponding secretary.

and Dr. W. Briggs Hopson of Vicksburg, secretary-treasurer.

The Mississippi Eye, Ear, Nose and Throat Association conducted a luncheon and business meeting on Tuesday at the Holiday Inn Downtown. Officers are president, Dr. Larry H. Day of Hattiesburg; vice president, Dr. J. Leighton Pettis of Tupelo; and secretary-treasurer, Dr. Wilson E. Moak of Jackson.

A luncheon meeting highlighted the annual gathering of the Mississippi Society of Internal Medicine. Dr. A. Robert Dill of Columbus is president and Dr. James C. Hays of Jackson is secretary and president-elect.

The Mississippi Neurosurgical Society held a luncheon program on Tuesday. Officers are president, Dr. Glen Warren of Jackson; secretary-treasurer, Dr. Lucien R. Hodges of Jackson; and vice president, Dr. Robert R. Smith of Jackson.

Preceding the section meeting on Wednesday, May 5, the Mississippi Ob-Gyn Society conducted



New officers of the Mississippi EENT Association are, from left, Drs. J. Leighton Pettis of Tupelo, vice president; Wilson Moak of Jackson, secretary-treasurer; and Larry Day of Hattiesburg, president.

a luncheon meeting. New officers are president, Dr. Richard Hollis of Amory; president-elect, Dr. Kenneth Pittman of Jackson; vice president, Dr. Lamar Gillespie of Hattiesburg; and secretary-treasurer, Dr. Lewis Lipscomb of Jackson.

Family physicians met at a Mississippi Academy of Family Physicians luncheon on May 5. Governor Cliff Finch was guest speaker. Officers are president, Dr. Richard T. Furr of Ocean Springs; president-elect, Dr. Walter Rose of Indianola; vice president, Dr. Frank Bowen of Carthage; and secretary-treasurer, Dr. John M. Estess of Hollandale.

The Mississippi chapter of the Flying Physicians Association, Inc. held a cocktail party and dinner on May 5. Dr. John J. White of Jackson was elected president and Dr. H. Davis Dear of Jackson is secretary-treasurer.

A Short Course in Practical Tonometry for Non-Ophthalmologists was again sponsored by the Mississippi EENT Association and the Mississippi Society for the Prevention of Blindness.

MSMA President Appears on TV



Participating in a television panel discussion concerning health care costs moderated by Howard Lett, left, were George Butler, president, Blue Cross and Blue Shield of Mississippi; C. Chandler Clover, chairman, Mississippi Hospital Association, and Jack A. Atkinson, M.D., president, Mississippi State Medical Association. The 30-minute program, Plain Talk on Health Care Costs, was aired on nine state television stations in prime time during April and May. The program was sponsored by Blue Cross and Blue Shield of Mississippi. A film version of the program (Sony cassette) is available for showing to medical staffs, hospital boards of trustees and department heads. Contact Public Relations Dept., Blue Cross-Blue Shield of MS, P.O. Box 1043, Jackson, MS 39205 (981-2511).

Dr. S. H. McDonnieal Is Recognized



After nine years on the board of directors of Blue Cross and Blue Shield of Mississippi, Dr. S. H. McDonnieal, Jr., left, of Jackson, receives a retirement gift from Lowery A. Woodall of Hattiesburg, board chairman, in recognition of his service. Dr. McDonnieal is a practicing internist.

Dr. E. M. Moffitt Elected to Blues Board



Dr. Ellis M. Moffitt of Jackson was elected to the board of Blue Cross and Blue Shield of Mississippi at the recent board meeting held in Jackson. The Plan serves more than 1.2 million Mississippians through its regular membership and government programs.

CLASSIFIED

NEEDED: One physician to work in an active University Student Health Center beginning July 1, 1976. Please contact J. C. Longest, M.D., Director, Mississippi State University, P. O. Box 5448, Mississippi State, Miss. 39762. Phone: 1-601-325-2431.

JOIN MPAC TODAY

PRINTING — OFFICE SUPPLIES

EQUIPMENT — FURNITURE



Premier Printing Company

2485 West Capitol Jackson, Mississippi

Phone 352-4091

Index to Advertisers

Blue Cross and Blue Shield of MS 18
Burroughs Wellcome Co. 10B

Canton Exchange Bank 11
Coca-Cola 14

Fidelity Bank 15

Hill Crest Hospital 16
Hyrex-Key Pharm. 4

Key Pharm., Inc. 17

Eli Lilly and Co. front cover

Mead Johnson Laboratories 12
MS State University 19

Pennwalt Prescription Products 162B, 162C, 162D
Pharmaceutical Manufacturers Assoc. 6, 7
Premier Printing Co. 19

Roche Laboratories
second cover, 3, 166, 166A, third and fourth covers
Roerig and Co. 166D, 168, 169

Sheraton-Biloxi 15
Smith Kline and French 166B

The Upjohn Company 166C

Warner-Chilcott Labs 10, 10A

Thomas Yates and Co. 8

IN CONCLUSION

HEW has established a new office to smooth the way for regulations. This goal of the Office of Regulatory Review is to involve people who will be affected by regulations before the regulations are written. The office is considering a procedure called "notice of intent to publish proposed rulemaking," under which an announcement of the intent to write regulations would be published in the Federal Register. The announcement would describe the issues to be covered and comments would be solicited.

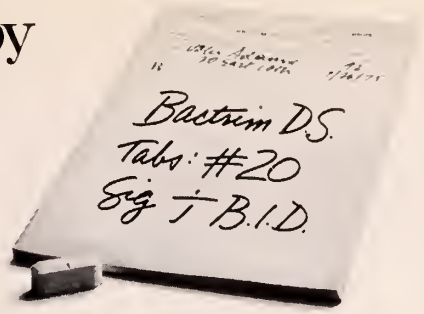
Recent clinical studies at the National Heart, Lung and Blood Institute and elsewhere indicate that echocardiography provides a non-invasive, safe, and sensitive means for detecting early, often asymptomatic alterations in heart structure and functions that may gradually progress to congestive heart failure in chronic alcoholics. The technique was equally effective in detecting cardiac deterioration occurring in patients with hemochromatosis or Cooley's anemia, said the report from the National Institute of Health.

The AMA has called for a re-opening of hearings by a congressional subcommittee on the subject of alleged unnecessary surgery. The call for new hearings was made in a letter to Rep. John E. Moss (D. Cal.), chairman of the Subcommittee on Oversight and Investigations of the Committee on Interstate and Foreign Commerce. In a critique of the subcommittee report accompanying the letter from AMA EVP Dr. James Sammons, the AMA said that none of the subcommittee's conclusions is valid for all are based on inaccurate or invalid data.

HEW has announced the availability of grants to foster more effective delivery of health services in rural areas. Under the Rural Health Initiative (RHI) program authorized by certain sections of the Public Health Service Act, grants will serve to promote integrated health systems in rural areas, using new approaches which will combine, coordinate and strengthen health service delivery resources in such areas. Objective is to encourage applicants to devise models for eventual designing, implementation and evaluation of rural health delivery.

The "average stay" in the hospital, excluding doctor bills or other extras, now costs almost $1,200, suggests a study by the Health Insurance Institute. The study, which covers rising health care costs through 1974, showed that the typical patient entering a hospital that year remained there for 7.8 days at an average daily cost of $127.70 or a total of $996.20 for the stay. This was an increase of almost 12 per cent over 1973 charges. Since 1974, hospital charges have risen approximately 15 per cent.

10-day Bactrim therapy outperforms 10-day ampicillin therapy.



In a multicenter, double-blind study of patients with chronic or frequently recurrent urinary tract infection, Bactrim 10-day therapy outperformed ampicillin 10-day therapy by 27.2%, when comparing patients who maintained clear cultures for eight weeks. Criterion for "clear culture" was 1000 or fewer organisms/ml of urine.

While adverse reactions noted in this study were mild (*e.g.*, vomiting, nausea, rash), more serious reactions can occur with these drugs. See manufacturer's product information for complete listing. Maintain adequate fluid intake; perform frequent CBC's and urinalyses with microscopic examination.

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

Bactrim™ DS
(160 mg trimethoprim and 800 mg sulfamethoxazole)
Double Strength tablets
Just 1 tablet B.I.D.

Bactrim™
(80 mg trimethoprim and 400 mg sulfamethoxazole)
2 tablets B.I.D.

For chronic or frequently recurrent cystitis and pyelonephritis due to susceptible organisms.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections evidenced by persistent bacteriuria (symptomatic or asymptomatic), frequently recurrent infections (relapse or reinfection), or infections associated with urinary tract complications, such as obstruction. Primarily for cystitis, pyelonephritis or pyelitis due to susceptible strains of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris* and *Proteus morganii.*

NOTE: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections. The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. **Data are insufficient to recommend use in infants and children under 12.**

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) every 24 hours
Below 15	Use not recommended

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole — bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; fruit-licorice flavored — bottles of 16 oz (1 pint).

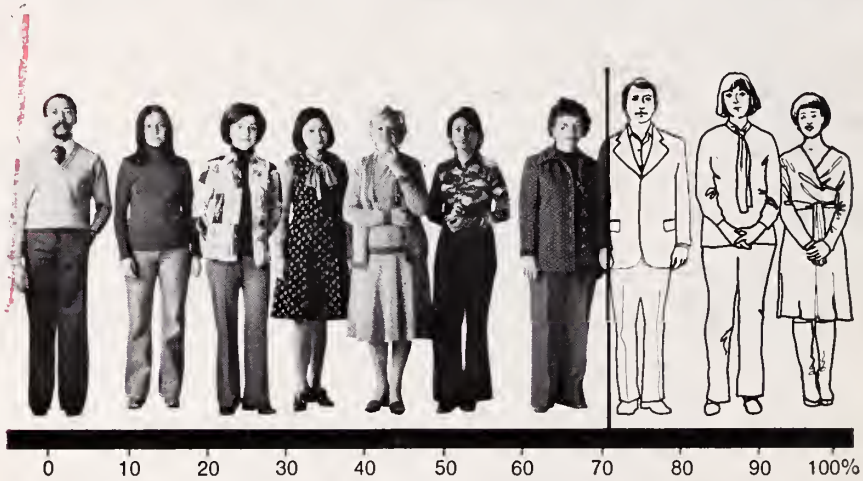
ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

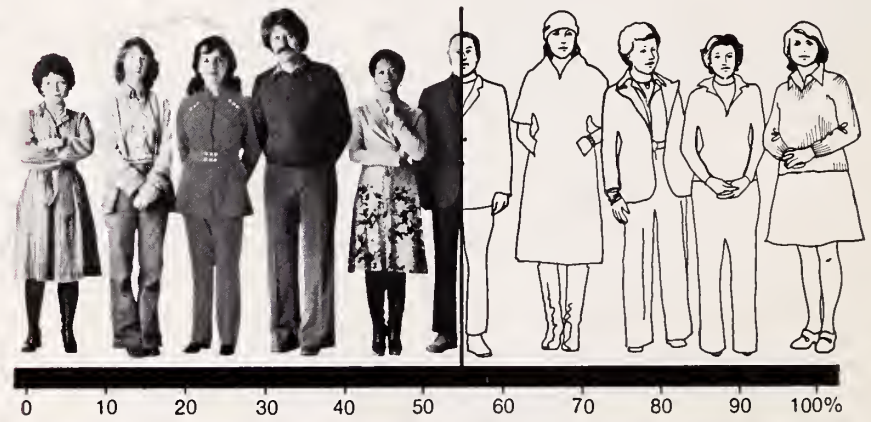
In a multicenter study of patients with chronic or frequently recurrent urinary tract inf

Bactrim was 27.2%* more effective than ampicillin in keeping patients infection-free for 8 weeks.†

LIBRARY
JUN 28 1976
NEW YORK ACADEMY OF MEDICINE



Bactrim–70.5% of 78 patients infection-free at 8 weeks.



ampicillin–55.4% of 74 patients infection-free at 8 weeks.

*This percentage is arrived at by the statistical method of dividing the difference between Bactrim and ampicillin results (15.1%) by the percent of ampicillin results (55.4%).

†Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110

Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

Double Strength tablets Just 1 tablet B.I.D.

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

Please see summary of product information on preceding page.

ROCHE

EAST 103RD ST
EW YORK N.Y.
10029

BALCONY

AMERICAN REVOLUTION BICENTENNIAL 1776-1976

JOURNAL OF THE Mississippi STATE MEDICAL ASSOCIATION

JULY 1976

New from Lilly/Dista Research

NALFON®
fenoprofen calcium
300-mg.* Pulvules®

DISTA
Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

Additional information available to the profession on request.

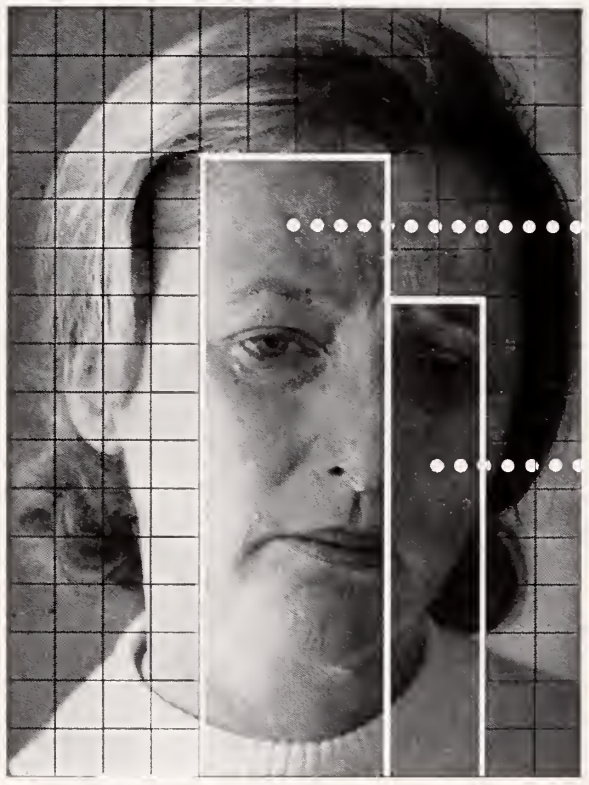
*Present as 345.9 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. fenoprofen.

600091

This Month . . . Postoperative Recurrent Peptic Ulcer, Colposcopy, Intravenous Voiding Cystourethrography

M.S.M.A

Both often



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium® (diazepam) (IV)

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Physicians Are Divided On Compulsory Service

A recent poll conducted by the AMA indicates that physicians are almost evenly divided on the question of whether young doctors who receive government loans or direct financial assistance to pay for their medical education should subsequently be required to serve for a period of time in medical shortage areas.

The poll found that 49.8 per cent of the doctors surveyed are opposed to such mandatory service in return for financial aid, while 45.4 per cent favor it. The others were undecided.

Among the physicians who voted for obligatory service in areas of medical need, older doctors (age 65 and over) are most strongly in favor (69.7 per cent). M.D.s in the 35-49 age bracket are least in favor.

When asked if they would require all graduating physicians—even those who had received no loans or financial assistance—to serve in shortage areas, 87 per cent of the doctors polled said no.

AMA Urges Discussion of Fees

With the cost of health care now rising at a monthly rate nearly twice that of the overall consumer price index, the American Medical Association is urging physicians to discuss their fees and services with their patients. The AMA notes that one practical approach to a discussion of fees and services is to revive use of an AMA plaque entitled, "To All My Patients." The attractive desk or wall plaque reads: "I invite you to discuss frankly with me any questions regarding my services or my fees. The best medical service is based on a friendly, mutual understanding between doctor and patient."

Bureau of Labor statistics indicate that the overall cost of medical services increased at a 14 per cent annual rate during the first three months of 1976. This is in contrast to a 8.9 per cent annual rate increase in other service prices and a 2.4 per cent annual rate increase in the overall consumer price index less medical care.

helping you change things for the better

Canton Exchange Bank

A FULL SERVICE BANK

"Your Account Handled in Strict Confidence"

Each depositor insured to $40,000

Branch Offices

Canton East Branch
Bank Of Madison
Bank Of Ridgeland

FDIC

"Our 95th Year Of Continuous Service"

Federal Deposit Insurance Corporation

Volume XVII
Number 7
July 1976



JOURNAL of the Mississippi
STATE MEDICAL ASSOCIATION

• EDITOR
W. Moncure Dabney, M.D.
• ASSOCIATE EDITORS
George H. Martin, M.D.
Myron W. Lockey, M.D.
• MANAGING EDITOR
Nola Gibson
• PUBLICATIONS COMMITTEE
Lawrence W. Long, M.D.
Chairman
Robert R. McGee, M.D.
T. A. Baines, M.D.
and the editors
• THE ASSOCIATION
Lyne S. Gamble, M.D.
President
James O. Gilmore, M.D.
President-Elect
J. Elmer Nix, M.D.
Secretary-Treasurer
C. D. Taylor, Jr., M.D.
Speaker
R. Faser Triplett, M.D.
Vice Speaker
Charles L. Mathews
Executive Secretary
H. Cody Harrell
Assistant Executive Secretary
William F. Roberts
Legal Counsel

The Journal of the Mississippi State Medical Association is owned and published monthly by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, $15.00 per annum; $2 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

CONTENTS

ORIGINAL PAPERS

Colposcopic Evaluation of the Female Lower Genital Tract **181** Robert W. Swan, M.D., Jackson, MS

Problems in Abdominal Surgery IV. Postoperative Recurrent Peptic Ulcer **184** William O. Barnett, M.D., Jackson, MS

SPECIAL ARTICLES

Radiologic Seminar CLXI: Intravenous Voiding Cystourethrography **187** Dan T. Keel, M.D., Brookhaven, MS

Address of the President **189** Jack A. Atkinson, M.D., Brookhaven, MS

Syphilis—Recommended Treatment Schedules, 1976 **191** Center for Disease Control, Atlanta, Ga.

EDITORIAL

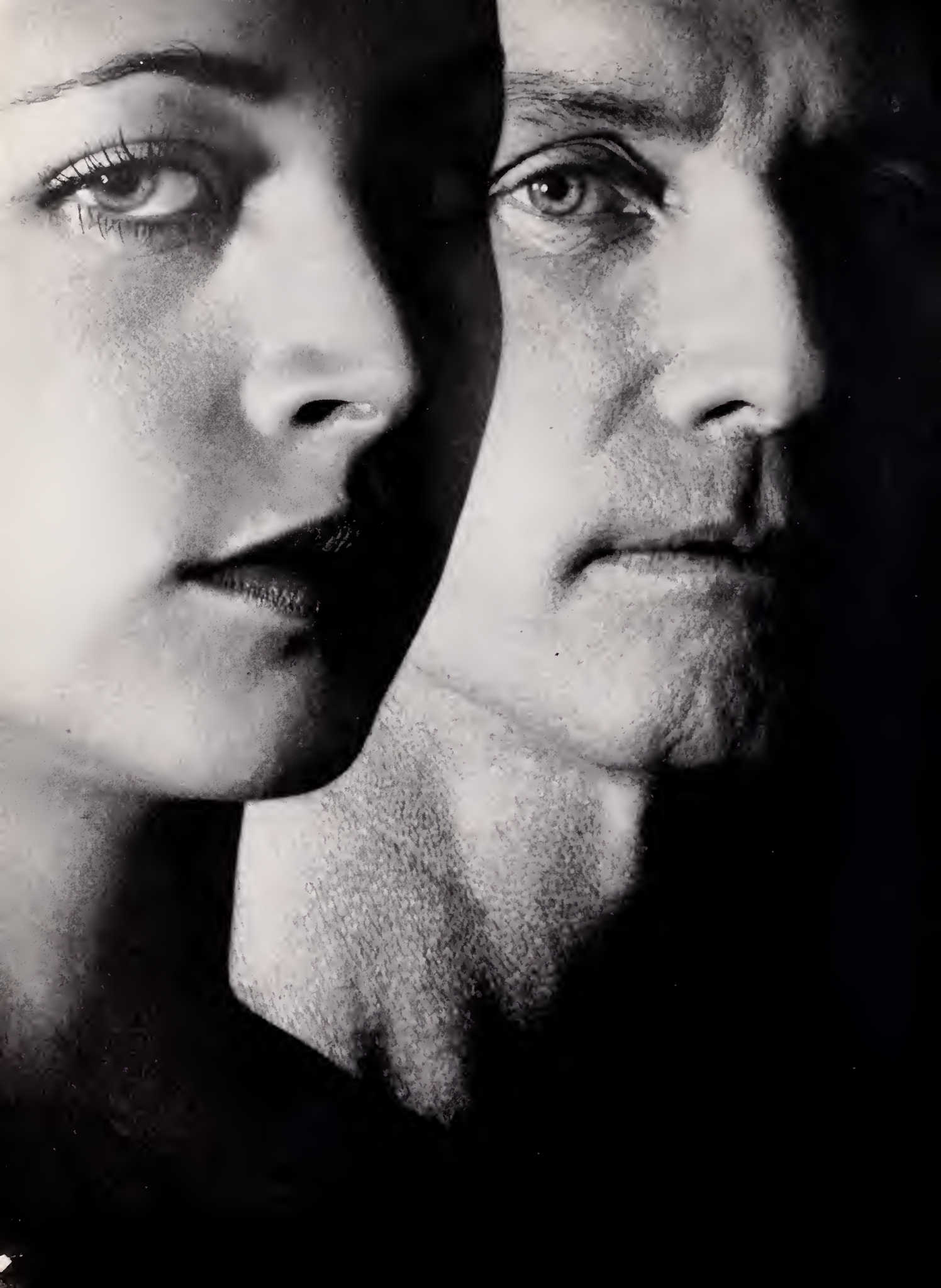
Postirradiation Carcinoma of the Thyroid Gland **195** George H. Martin, M.D., Vicksburg, MS

THIS MONTH

The President Speaking **194** "Objectives of Medical Injury Compensation System"

Medical Organization **201** Health Planning Potpourri

Copyright 1976, Mississippi State Medical Association



Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

TO COMPLETE YOUR HEALTH INSURANCE PICTURE, MSMA OFFERS ITS NEW COMPLETE HEALTH INSURANCE PACKAGE:

NEW MAJOR MEDICAL PLAN
Covers 80% of your eligible expenses after you satisfy your deductible amount. Choice of deductibles available. Pays expenses in and out of the hospital!

NEW HOSPITAL MONEY PLAN®
Pays a daily benefit for each day you spend in the hospital because of an accident or illness. Acceptance is GUARANTEED! Pays the benefits directly to *you*!

NEW EXCESS MAJOR MEDICAL PLAN
Picks up where basic insurance programs leave off. Pays 100% of eligible expenses in or out of the hospital—up to $250,000 maximum. And, premiums are LOW! Acceptance is GUARANTEED!

A complete health insurance picture is probably one of the most important items you can provide for your family's financial well-being. To help you combat the rising cost of hospital and medical care, MSMA has entirely revamped its health insurance program to give you the most complete and comprehensive program available . . . and at a low price all can appreciate. Find out more. Mail the coupon below for more information:

THE MSMA INSURANCE PROGRAMS ARE UNDERWRITTEN BY:



CONTINENTAL CASUALTY Co.
ASSOCIATION GROUP DIVISION
Chicago, IL 60685

a division of CNA/insurance

Please send me more details on the NEW MSMA insurance programs:

☐ **MSMA MAJOR MEDICAL PLAN** ☐ **MSMA HOSPITAL MONEY PLAN** ☐ **MSMA EXCESS MAJOR MEDICAL PLAN**

NAME_____

ADDRESS_____

CITY_____

STATE_____ ZIP CODE_____

MAIL TO: Thomas Yates & Co., MSMA Insurance Administrators
P.O. Box 1054, Jackson, Mississippi 39205

NEWSLETTER

July 1976

Dear Doctor:

During the 1976 legislative session several amendments to the mental commitment law were adopted. A significant change allows the person to be committed or his attorney to waive his rights to the required judicial proceedings in order to permit the individual to be admitted to a mental facility immediately without the required 72 hour waiting period. Another change expands the "hold harmless" provision to include any physician who acts in good faith in carrying out the law.

> If there is a substantial risk of imminent physical harm to oneself or others during the pre-admission hearing period then the clerk or chancellor may order the individual to be retained as an emergency patient at a mental hospital, mental health center, or any hospital or jail. For more details, contact MSMA.

Nine thousand dollars is the average debt of 7 out of 10 medical students when they reach the final year of school, the Association of American Medical Colleges reports. The AAMC "Survey of How Medical Students Finance Their Education 1974-1975" also shows that one third of the students come from families with incomes below $15,000 and slightly more from families with $25,000 plus.

All pediatricians should report cases of fireworks injuries over the Bicentennial Fourth of July holiday to a central, federal accident registry, the American Academy of Pediatrics has urged. In order to report the injuries, physicians should call the Consumer Product Safety Commission's toll free number, 800-638-2666. The AAP calls for a ban on all fireworks.

Representatives from many state medical societies attended a recent professional liability insurance seminar conducted by the AMA in Chicago. Some 15 state medical societies are now in the process of organizing their own "captive" companies to provide professional liability coverage. The AMA has announced formation of a company to provide reinsurance to local captive companies.

The Mississippi State Medical Association's Council on Medical Education has contacted all members to notify them that they may now submit information about their attendance at continuing medical education programs to the MSMA office for annual reporting back to them. The council is also encouraging Mississippi hospitals and medical organizations to seek accreditation of their CME programs.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

MSMA Is Involved In Chiropractic Suit

As of July issue of JOURNAL MSMA went to press, MSMA's lawsuit against a Jackson chiropractor was being tried. The lawsuit authorized by the MSMA House of Delegates in 1975 to prohibit chiropractors from engaging in activities constituting the practice of medicine came up for trial on June 15 in a Hinds County Chancery Court. The suit charges a Jackson chiropractor with utilizing treatment modalities and prescribing vitamins in violation of the 1973 Chiropractic Licensure Act and the Medical Practice Act. The suit also alleges that the use of these modalities and the prescribing of vitamins and food supplements constitute a public nuisance that should be permanently enjoined by the court. Newspaper accounts of the trial have stated the lawsuit could result in a "landmark decision" affecting the scope of chiropractic practice.

Vice Presidents Serve as Liaison Officers

MSMA president, Dr. Lyne S. Gamble, recently met with the association's three vice presidents to map out plans for improving communications between MSMA and its 18 component societies. The decision to utilize the vice presidents in the role of liaison officers came out of a meeting between MSMA and component society officers during the 108th Annual Session. In addition to their duties in the area of membership recruitment the vice presidents will serve as the primary communications link between the societies in their district and the MSMA state office. It is expected that this increase in duties for the vice presidents will result in more timely communication between MSMA and its membership on such matters as legislation, the new federal health planning law activities and other matters of importance to the profession. The three newly elected MSMA vice presidents are: Dr. J. Edward Hill (Northern District), Dr. Hardy B. Woodbridge (Central District) and Dr. Brantley B. Pace (Southern District).

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate in vitro sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

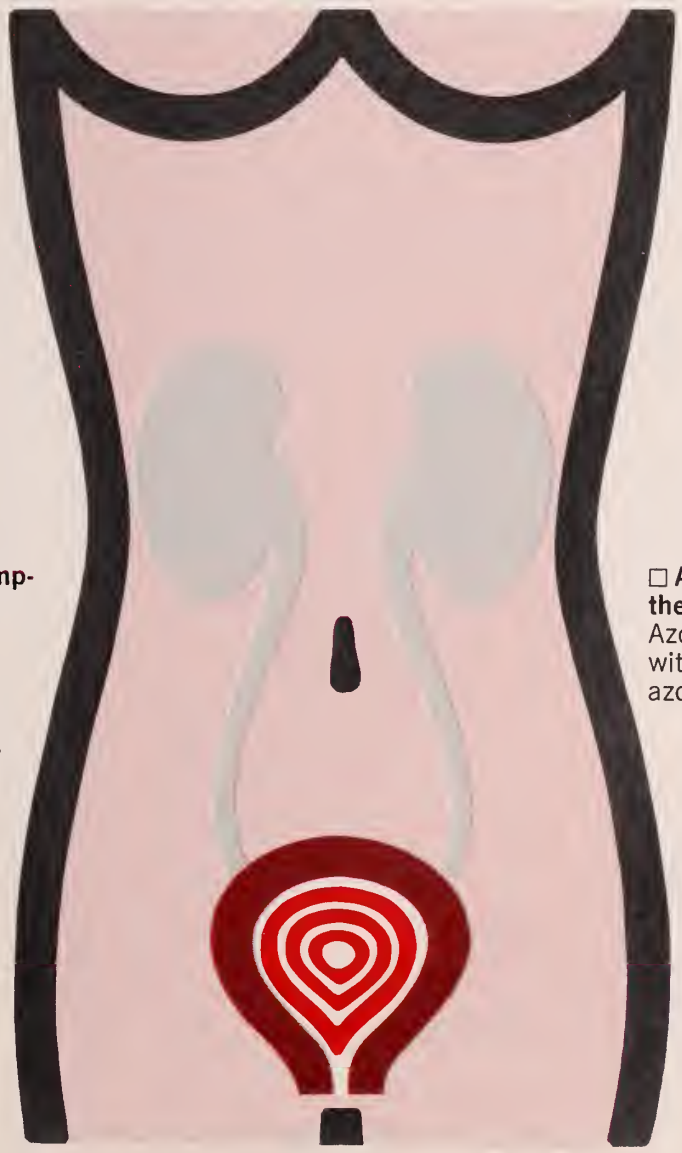
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

When pain complicates acute cystitis*

Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

for the pain for the pathogens



☐ **Early relief of painful symptoms** such as burning and discomfort associated with urgency and frequency.

☐ **Effective control of susceptible pathogens** such as *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris.*

☐ **Appropriate antibacterial therapy:** up to three days with Azo Gantanol, then 11 days with Gantanol® (sulfamethoxazole).

*nonobstructed; due to susceptible organisms

ROCHE

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*



Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Warning**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F CO., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

Upjohn

The Upjohn Company, Kalamazoo, Michigan 49001

Medrol® 4 mg Dosepak*

methylprednisolone, Upjohn

The explicit printed dosage instructions that accompany each Dosepak make it easy for the patient to understand and follow the dosage regimen.





When Big Ben looks "a little off"...

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

▪ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

▪ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*

▪ **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

New easy•to•understand comprehensive health care coverage for group members

Comp80 Contract

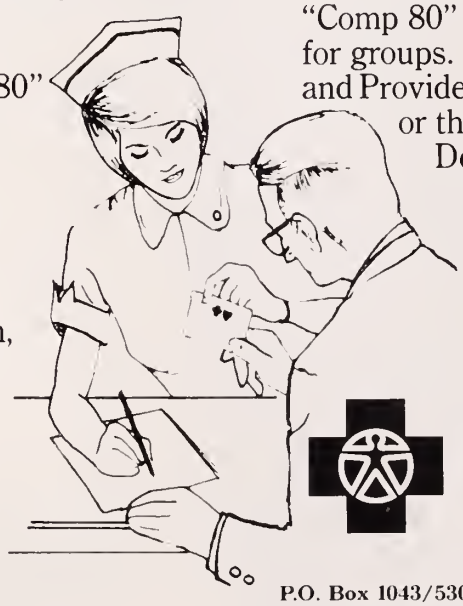
Now, to help make health care coverage easier to understand and to simplify handling of claims and payments, the Blue Cross and Blue Shield Plan introduces the new "Comp 80" Contract which combines both basic and major medical coverage into one contract.

It works this way:

The New "Comp 80" Contract has an all-illness deductible for each calendar year. This means that the "Comp 80" Contract will not pay anything for hospital, physician, or outpatient services until the member has paid the initial predetermined amount of covered expenses. After the deductible has been paid by the member, the Plan will pay 80% of covered expenses up to a lifetime maximum of $250,000.

This simple, easy-to-understand "Comp 80" Contract is now available for groups. Contact your Professional and Provider Relations Representative or the Customer Services Department for full details.

Working together, we can help contain the rising costs of health care.



Blue Cross
Blue Shield
of Mississippi

P.O. Box 1043/530 E. Woodrow Wilson Ave./
Jackson, Mississippi 39205/Tel. 982-0010

*Registered Marks Blue Cross Association
*Registered Service Marks of the National Association of Blue Shield Plans

DATELINE

New Journal Is Announced

Chicago, IL - The University of Chicago Press announces publication of The Journal of Medicine and Philosophy, a quarterly founded to explore and stimulate discussion of the shared themes and concerns of these two disciplines. The new journal is published under the auspices of the Society for Health and Human Values and is edited by Edmund D. Pellegrino, professor of medicine at Yale. Subscriptions are $15.00 from the University of Chicago Press, 5801 S. Ellis Ave., Chicago 60637.

Family Therapy Approaches Studied

Washington, DC - Ways by which family interaction might perpetuate drinking, how family rituals might contribute to transmission of alcoholism from parent to child, the role of the nonalcoholic spouse, and the effect of drunkenness on the way the family functions are being studied by George Washington University psychiatrist Peter Steinglass in a 3-year project funded by the National Institute on Alcohol Abuse and Alcoholism.

Home Deliveries Are Opposed

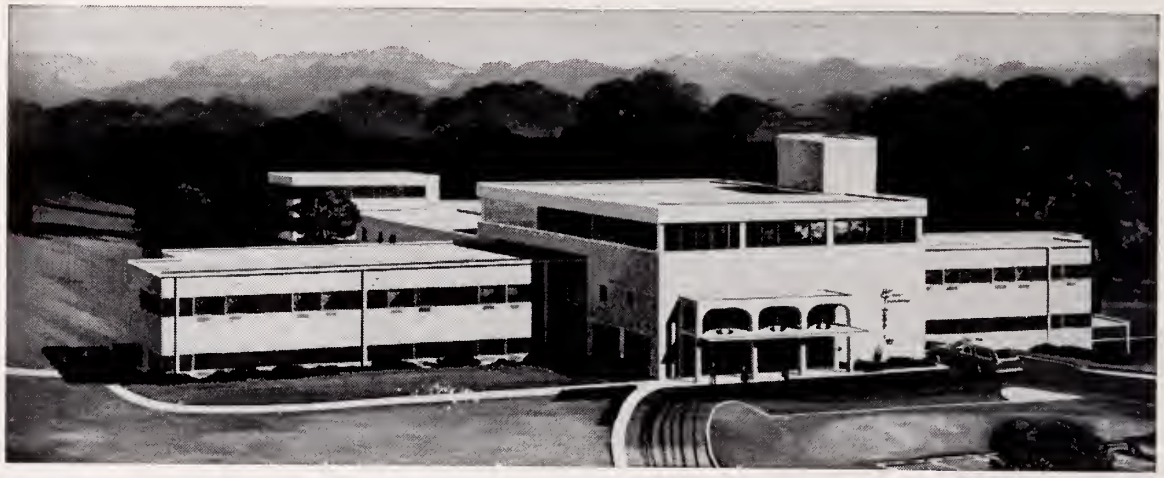
Randolph, VT - Concerned over what appeared to be a rise in the number of home deliveries in their area, the Gifford Memorial Hospital medical staff issued a statement to the local press, voicing strong disapproval of home deliveries and laying out the reasons why they took that position. The action was initiated after instances where area women attempting home deliveries had to be brought into the hospital for such emergencies as fetal distress and maternal bleeding.

Human Milk Is Safe for Prematures

Evanston, IL - All available evidence suggests that it is safe to feed human milk to premature infants, a workshop of top scientists has indicated, but much more research needs to be done, according to a report in May issue of Pediatrics. Some of the possible advantages of breast milk for prematures, the report said, include "ready digestibility and absence of foreign proteins; in addition, it is possible that feeding of human milk may protect against enteric (intestinal) infection."

Patients Urged to Bank Own Blood

Chicago, IL - "The only definitely safe blood for transfusion is blood removed from an individual and subsequently reinfused into that same individual," reports Dr. Herbert Silver in JAMA. Dr. Silver, of the blood bank of Hartford Hospital, Hartford, CN, described the technique and said routine preoperative collections of blood from patients who are to have elective surgery can go a long way in helping to eliminate not only diseases transmitted through blood but other reactions.



HILL CREST HOSPITAL

For Intensive Treatment of Psychiatric Disorders

This 101-bed non-governmental psychiatric hospital provides modern facilities for diagnosis and treatment of patients with all degrees of illness, including those who show severely disturbed behavior. Alcoholic and drug abuse patients are also accepted.

In addition to care by psychiatrists and by consultants in all medical specialties, the treatment program includes occupational, recreational, and physical therapy, social services, and tutoring. Emphasis is on short-term, intensive treatment of voluntary patients.

Hill Crest is a member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Alabama Hospital Association, Birmingham Regional Hospital Council.

Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved. Blue Cross Participating Hospital.

ADMINISTRATOR: Robert V. Sanders

HILL CREST HOSPITAL

HILL CREST FOUNDATION, INC.

6869 Fifth Avenue South **Birmingham, Alabama 35212**

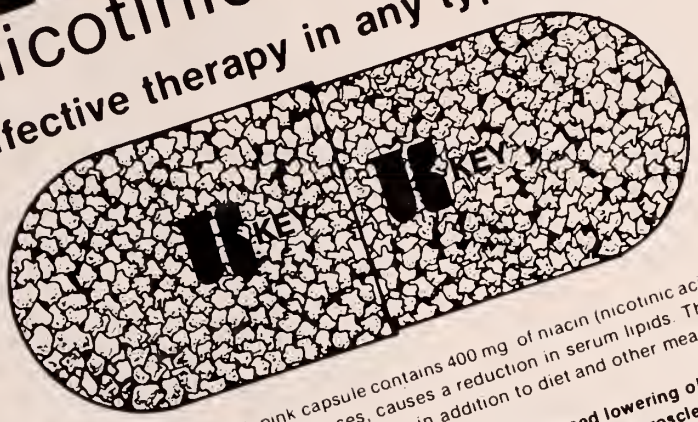
PHONE: 205-836-7201

The Original
Slow Release
Form of Nicotinic Acid

nico-Span®

(nicotinic acid) 400 mg. capsules

Effective therapy in any type of drug responsive hyperlipidemia.



DESCRIPTION: Each pink capsule contains 400 mg. of niacin (nicotinic acid) in a special pelletized formulation for prolonged release.

ACTIONS: Niacin, in large doses, causes a reduction in serum lipids. The exact mechanism of action is unknown.

INDICATIONS: As adjunctive therapy in addition to diet and other measures in the treatment of hypercholesterolemia and hyperbetalipoproteinemia.

Notice: It has not been established whether drug-induced lowering of serum cholesterol or other lipid levels has a detrimental, a beneficial or no effect on the morbidity due to atherosclerosis or coronary heart disease. Several years will be required before current investigations can yield an answer to this question.

CONTRAINDICATIONS: Niacin is contraindicated in patients with hepatic dysfunction or in patients with active acute peptic ulcer.

WARNINGS: The use during pregnancy and lactation or in women of childbearing age requires careful weighing of potential benefits versus possible hazards to the mother and child. There are insufficient studies done for usage in children.

PRECAUTIONS: Patients with diabetes, gall bladder disease, past history of jaundice, liver disease, or peptic ulcer should be observed closely. At initial stage of therapy, liver function and blood glucose should be monitored at frequent intervals. Adjustment of diet and/or hypoglycemic therapy may be necessary. Patients undergoing antihypertensive therapy may experience an added vasodilating effect with resulting postural hypotension. Use with caution in patients predisposed to gout.

ADVERSE REACTIONS: Severe flushing, decreased glucose tolerance, activation of peptic ulcer, abnormal liver function tests, jaundice, gastrointestinal disorders, dry skin, pruritus, hyperuricemia, toxic amblyopia, hypotension, transient headache.

DOSAGE AND ADMINISTRATION: The dose and frequency for the administration of NICO-SPAN should be adjusted to the response of the patient. Slow build-up of dosage in gradual increments is recommended to observe efficacy and/or adverse effects. One or two capsules three times a day is the usual dosage. The maximum daily dosage is 6 grams.

Please arrange to provide starter samples and/or complimentary "Starter" prescription booklets for: **nico-Span®** (nicotinic acid, 400 mg.)

Samples ☐ "Starter" Rx's ☐

Dr. _____ Specialty _____

Street _____ State _____

City _____ Zip _____

Mail to: Key Pharmaceuticals, Inc. 50 N.W. 176th Street, Miami, Florida 33169

KEY PHARMACEUTICALS, INC.
Miami, Florida 33169 (U.S.A.)

ANNOUNCING . . .

One day workshops for your medical office assistants . . . office managers, receptionists, medical secretaries, bookkeepers, insurance clerks and nurses.

BUSINESS ESSENTIALS FOR A MEDICAL OFFICE

SCHEDULE

9:00 a.m. to 5:00 p.m.

July 28, 1976	**Jackson**	**Jackson Hilton**
July 29, 1976	**Biloxi/Gulfport**	**Biloxi Hilton**

Faculty from PRACTICE PRODUCTIVITY INC., a national management consulting firm which offers educational and motivational workshops in sound business concepts to physicians and their medical assistants, and provides in-depth consulting to physicians in private practice. For further information on Practice Productivity Inc. contact Duane M. Johnson, Ph.D., Executive Vice President, (404) 455-7344.

WORKSHOP AGENDA

MORNING SESSION
9:00 a.m. to 9:30 a.m.
Introduction . . . The Importance of Business Essentials
9:30 a.m. to 12:30 p.m.
Telephone management . . . what to say and how to say it; educating the patient about the practice; helpful techniques and useful equipment. Appointment scheduling . . . developing a schedule that works and making it work. Medical records . . . structuring the content; effective filing procedures; dictation aids.

LUNCHEON
12:30 p.m. to 2:00 p.m.
Included in registration fee

AFTERNOON SESSION
2:00 p.m. to 5:00 p.m.
Personnel . . . conflict, cause and cure; utilizing your skills; motivation tips. Billing systems and collections . . . improving patient understanding; improving the collections system. Insurance claims processing . . . defining obligations, finding a better way. Implementation . . . putting it all to work.

Registration Form

Please register the following persons (please type or print):

Name	*Position*	*Date Will Attend*
1.		
2.		
3.		
4.		

From the office of:

Name _____ **Telephone ( )** _____

Address _____

City _____ **State** _____ **Zip** _____

Full tuition fee of $ ..... is enclosed at $50 per registrant. Tuition includes course materials and luncheon and must accompany this form. There is a $10 handling fee deducted on all refunds for cancellations received at least one week in advance; no refund thereafter. Please mail to:

Practice Productivity Inc.
2000 Clearview Avenue
Atlanta, Georgia 30340
Phone (404) 455-7344

Continuing Education Is Endorsed

More than two-thirds of physicians surveyed in a recent poll say they favor a continuing medical education requirement as a prerequisite to re-registering their licenses.

Physician opinion on who should assure compliance with the continuing education requirement was divided. State medical associations were preferred by almost 30 per cent. Others suggested medical specialty organizations, state medical examining boards, and the American Medical Association.

Almost three-fourths of the doctors surveyed said they agreed with the suggested national baseline of 150 hours of continuing education every three years.

Based on action of the MSMA House of Delegates at the recent 108th Annual Session, a program to require CME as a condition for continued membership in the association will be presented for approval at next year's annual session.

Cancer Deaths May Be From Bad Habits

The National Cancer Institute has recently released statistics which indicate that some 100,000 cancer deaths in this country—30 to 40 per cent of the annual total—could be prevented by changes in people's smoking, drinking and eating habits.

NCI estimates that some 70,000 of the 80,000 people who die from lung cancer each year would remain alive if they stopped smoking.

Increased consumption of roughage could cut the annual death toll from colon cancer from 30,000 to 20,000 deaths. Other diet changes could save another 15,000 lives and 5,000 breast cancer deaths could be prevented if American women ate less animal fats.

Finally, NCI estimates that if those who drink and smoke thus increasing the risk from head, neck or esophageal cancers would stop, some 5,000 lives could be saved.

Is there a tablet containing *only* an expectorant and *only* Glyceryl Guaiacolate? YES!

1. Patient acceptable tablet dose.
2. Single entity expectorant.
3. Measured tablet dose.
4. Sugar-free tablet.

An identifiable white, scored tablet which significantly stimulates the secretion of respiratory tract fluid.

HYTUSS TABS

(GLYCERYL GUAIACOLATE 100mg.)





Composition: Each sugar-free compressed tablet contains glyceryl guaiacolate 100mg. **Action and Use:** This preparation utilizes the effective expectorant action of glyceryl guaiacolate which significantly stimulates the secretion of respiratory tract fluid. The increased flow of less viscid fluid favors expectoration and has a demulcent effect on the tracheobronchial mucosa. The primary usefulness of Hytuss Tabs is to promote the change from a dry, unproductive cough to a productive cough. Hytuss is therefore useful in treating coughs due to the common cold, bronchitis, laryngitis, tracheitis, pharyngitis, influenza and the measles. The expectorant action of Hytuss may also provide symptomatic relief in some chronic respiratory disorders when the patient experiences spasms of dry nonproductive coughing. **Precautions:** Extremely large amounts may cause nausea and vomiting. **Administration and Dosage:** *Adults*—1 tablet four times daily. *Children*—6 to 12 years of age; ½ tablet 3 or 4 times daily. HOW SUPPLIED: White, scored, sugar-free, tablet in bottles of 100 - 1,000 - 5,000. **Product Identification Mark:** Hy. **Literature Available:** On request.

Available through all drug wholesalers.

Hyrex

HYREX COMPANY

832 South Cooper
Memphis, Tenn. 38104

consider the effect on coexisting diabetes when you prescribe a vasodilator*



(POSTERIOR VIEW OF PANCREAS)

no interference in the management of the diabetic patient has been reported with

VASODILAN®
(ISOXSUPRINE HCl)

TABLETS, 20 mg.

the compatible vasodilator

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

Mead Johnson LABORATORIES

© 1976 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL-54117

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
July 1976, Vol. XVII, No. 7

ORIGINAL PAPERS

Colposcopic Evaluation of the Female Lower Genital Tract

ROBERT W. SWAN, M.D.
Jackson, Mississippi

COLPOSCOPY has been instrumental in defining the extent of early genital neoplasia in women.[1-6] When combined with cytology, the diagnostic accuracy has been reported over 98 per cent.[3] Such accuracy has led to markedly reduced conization rates in patients presenting with abnormal papanicolaou smears.[3, 4, 6] This is especially relevant to high risk patients such as those who are pregnant[6] or who undergo post-radiation for pelvic malignancy.

Quality control is important to any medical community providing a referral service. An ongoing prospective study was initiated at the University of Mississippi Medical Center in order to better evaluate our accuracy with colposcopy.

One hundred and four consecutive patients, both private and clinic, were evaluated for abnormal vaginal cytology or a history of diethylstilbestrol exposure in utero. All patients were seen between July 1, 1974, and April 1, 1975.

Each patient was interviewed. On examination, the uterine cervix and upper vagina were examined through the colposcope after which cytologic material was collected. Any suspicious area(s) was "scraped" directly. Three per cent acetic acid was applied to the cervix and/or vagina with colposcopic examination repeated. Schiller's solution was applied only if no definite lesion(s) was found. Under colposcopic direction, biopsies were taken from the "colposcopically worst" areas. If no "colposcopically abnormal" areas were found, the cervix was biopsied at the 6 and 12 o'clock positions. If the cervix was surgically absent or obscurred, a random vaginal "vault" biopsy was obtained.

Colposcopy has been instrumental in defining the extent of early genital neoplasia in women. When combined with cytology, the diagnostic accuracy has been reported over 98 per cent and has led to reduced conization rates in patients with abnormal pap smears. The author conducted a study of 104 consecutive patients to determine the accuracy rate at the University Medical Center. Materials, methods, and results are given.

A colposcopic impression was recorded, with the physician attempting not to be influenced by the cytologic history. This colposcopic impression along with the cytologic and histologic results were compared with the surgical specimens obtained from conization, hysterectomy and/or vaginectomy. A separate comparison was made for patients not having "surgical specimens," using the directed biopsy as the final pathology specimen.

Occasionally, a colposcopic examination was considered unsatisfactory due to inadequate visualization of the cervix and/or vagina.

Conizations were performed (1) when the colposcopic examination was unsatisfactory, (2) when

From the Department of Obstetrics and Gynecology, Division of Gynecologic Oncology, University of Mississippi School of Medicine, Jackson, MS.

there was significant disagreement between the colposcopic impression, cytology and/or biopsies, or (3) when definite therapy without hysterectomy was desirable.

Colposcopic, cytologic and histologic diagnoses were classified as follows: normal, dysplasia (mild, moderate, or severe), carcinoma in situ, microinvasion (5 mm. or less) and invasion. Positive correlation was defined as agreement within one grade of atypia in the dysplasia and carcinoma in situ categories. However, correlation had to be exact in the microinvasion and invasion categories.

Patient Composition. Of the 104 patients evaluated, 99 were referred with abnormal cytology. Of these 99 patients, 12 were pregnant and 8 had been previously treated with pelvic radiation. There were 5 patients referred with normal cytology who had a history of diethylstilbestrol exposure to utero (see Table 1).

Age. The age range was 11-83 years with the largest group in the third decade of life (see Table II).

Race. Racial distribution is seen in Table III.

Outcome. The final pathology diagnosis ranged from mild dysplasia to invasive cancer with the most frequent diagnosis being carcinoma in situ. Twenty-one patients had completely negative examinations (see Table IV).

TABLE I

COMPOSITION OF PATIENTS WITH RESPECT TO REASON FOR REFERRAL

Reason for Referral		*No. Pts.*
Abnormal Cytology		99
Non-pregnant	79	
Pregnant	12	
Previous radiation	8	
Normal Cytology*		5
Total		104

* These patients presented with histories of exposure to to diethylstilbestrol in utero.

TABLE II

RANGE OF AGES IN PRESENT SERIES

Age Range (Yrs.)	*No. Pts.*
10-19	11
20-29	35
30-39	30
40-49	8
50-59	8
60-69	4
70-	8
Total	104

TABLE III

RACIAL DISTRIBUTION

Race	*No. Pts.*
Black	78
White	25
Indian	1
Total	104

TABLE IV

FINAL PATHOLOGY DIAGNOSIS

Pathology Diagnosis	*No. Pts.*
Negative	21
Dysplasia	
Mild	13
Moderate	10
Severe	16
Carcinoma in situ	35
Micro-invasion	2
Occult invasion	7
Total	104

For anatomical reasons, colposcopic evaluation was inadequate in 11 of 104 patients (10.5 per cent). Diagnostic conizations were performed in these patients. There were 93 patients remaining who had satisfactory colposcopic evaluation. Of these 93 patients, there were 59 patients having biopsies as the only available histology. The remaining 34 patients had surgical specimens including conizations, hysterectomies, combinations of conizations/hysterectomy and vaginectomies.

The final source of pathology, i.e. "directed biopsies" or "surgical specimens" was used to correlate accuracy of the colposcopic impression, cytology and directed biopsy. When directed biopsies served as the final source, correlation was 68 per cent. When surgical specimens served as the final source, the correlation was 100 per cent (see Table V).

In the surgical specimen group (34 patients), each parameter (directed biopsies, cytology, colposcopic impression) was evaluated individually against the final pathology diagnosis. With respect to directed biopsies, there was an 82 per cent (28/34) accuracy, cytology a 74 per cent (25/34) accuracy, and colposcopic impression a 100 per cent accuracy. When cytology and directed biopsies were evaluated and then compared with the surgical specimens, there was a 97 per cent accuracy. One patient with micro-

TABLE V

ACCURACY OF "COLPOSCOPIC IMPRESSION" WHEN EVALUATED AGAINST THE SOURCE OF THE FINAL PATHOLOGY SPECIMEN

Final Source of Tissue	*No. Patients*	*Correct Correlation (No. Pts.)*	*(%)*
Directed biopsy	59	39	68
Surgical specimen	34	34	100

TABLE VI

COMPARISON OF ACCURACY USING DIFFERENT MODALITIES IN EVALUATING THE ABNORMAL PAP SMEAR WHEN SURGICAL SPECIMENS ARE AVAILABLE

Method of Evaluation	*No. Patients*	*Correct Correlation (No. Pts.)*	*(%)*
Directed biopsy	34	28	82
Cytology	34	29	85
Combination biopsy/ cytology	34	33	97
Colposcopic impression	34	34	100

invasion (2 mm.) was correctly diagnosed colposcopically but incorrectly diagnosed as carcinoma in situ by cytology and directed biopsies (see Table VI).

No occult or grossly invasive cancers were misdiagnosed in this series.

DISCUSSION

The colposcopic examination (cytology, directed biopsies and the colposcopic impression) has emerged as a very reliable method of evaluating the abnormal pap smear.[3, 6]

This reliability has been reduplicated in the present series. The finding of 97 per cent accuracy is in complete agreement with that reported in the literature. However, the finding of 100 per cent accuracy using the colposcopic impression alone with patients having surgical specimens is misleading. This may reflect small numbers of patients (34) as well as knowledge of the cytology upon referral.

It should be emphasized that the source of the "final pathology specimen" greatly influenced correlation with the colposcopic impression. In this series, "the directed biopsy" did not support the initial impression as did the "surgical specimen" (see Table V). This may reflect the inability, in many cases, to adequately biopsy from relatively "inaccessible" areas.

The conization rate of 10.5 per cent in this series is comparable to 5.6 per cent[6] and 15 per cent[4] reported in the literature. This wide variation may reflect the confidence of the examiner as well as the relative number of menopausal patients in a particular series. The incidence of unsatisfactory colposcopic examinations leading to diagnostic conization increases significantly after the menopause.[6]

It is significant that no conizations were performed in any pregnant patient. Stafl and Mattingly examined 89 pregnant patients with diagnostic conizations avoided in each case.[6]

From the foregoing presentation, previous enthusiasm for colposcopy can be supported. If the limitations of colposcopy are respected, the colposcopic examination should remain a safe and valuable tool in the diagnostic evaluation of the abnormal pap smear. ★★★

2500 North State Street (39216)

REFERENCES

1. Crapanzano, Joseph T. Office diagnosis in patients with abnormal cervicovaginal cytosmears: correlation of colposcopic biopsy and cytologic findings. Amer. J. Obstet. Gynecol. 113:967-72, 1 Aug. 1972.
2. Kolstad P. Carcinoma of the cervix: Stage O: Diagnosis and treatment. Amer. J. Obstet. Gynecol. 96:1098-1111, 1966.
3. Navratil E., Bajard F., and Nash W. Simultaneous colposcopy and cytology used in screening for carcinoma of the cervix. Amer. J. Obstet. Gynecol. 75:1292-97, 1958.
4. Ostergard, Donald R. and Gondos, Bernard. Outpatient therapy of preinvasive cervical neoplasia: selection of patients with the use of colposcopy. Amer. J. Obstet. Gynecol. 115:783-85, 15 March, 1973.
5. Stafl, A. Colposcopy in diagnosis of cervical neoplasia. Amer. J. Obstet. Gynecol. 115:286-7, 15 Jan. 1973.
6. Stafl, A. and Mattingly, Richard F. Colposcopic diagnosis of cervical neoplasia. Obstet. Gynecol. 41:168-76, Feb. 1973.

JOHN ADAMS ON THE FOURTH OF JULY

"I am well aware of the toil and blood and treasure it will cost us to maintain this Declaration. Yet through all the gloom I see the rays of ravishing light and glory. This is our day of deliverance. With solemn acts of devotion we ought to commemorate it. With pomp and show, games, sports, guns, bells, bonfires and illuminations from one end of the continent to the other from this time forth forevermore." *John Adams*

Problems in Abdominal Surgery
IV. Postoperative Recurrent Peptic Ulcer

WILLIAM O. BARNETT, M.D.
Jackson, Mississippi

FEW CIRCUMSTANCES in patient management are more disenchanting for the patient, his physician and his surgeon than those resulting from the reappearance of ulcer symptoms after the physical discomfort and financial stress of attempted definitive surgery. The history of ulcer surgery is intimately related to efforts expended toward minimizing recurrent ulceration. This problem, of course, was responsible for the elimination of gastroenterostomy as a primary procedure for ulcer management. It also led to higher and more extensive gastric resections with the accompanying postgastrectomy problems. The incidence of postoperative ulcer formation has been a major point of controversy in the development of vagotomy and auxiliary procedures for duodenal ulcer. Recurrent ulcer probably represents the most common of the severe problems which occur after ulcer surgery. The overall incidence is likely to be in the neighborhood of 10 per cent. Experience suggests that postoperative ulceration is highest after vagotomy and a drainage procedure and lowest when resection is combined with vagotomy. Usually the ulcer is located on the bowel segment which has been affixed to the stomach in reestablishing gastrointestinal continuity.

Factors in Pathogenesis. There are many circumstances which favor the formation of peptic ulcers after operative procedures (see Figure 1). Gastric resection without vagotomy continues to be used as a definitive operation. Where the extent of stomach removal is inadequate, recurrent ulcer is likely to occur. Retention of the gastric antrum can be responsible for postoperative ulceration, especially when the antral mucosa is exposed to an alkaline environment. Incomplete vagotomy represents a common etiology for recurrent peptic ulcer. This is related to the fact that accessory vagal fibers are common findings, and surprisingly enough, one of the main trunks may remain intact after alleged vagotomy. The Zollinger-Ellison syndrome is fortunately a relatively uncommon finding, but must be considered, especially where a fulminating ulcer diathesis is observed. Other predisposing factors include a long afferent loop and nondependent gastric drainage after vagotomy.

From the Department of Surgery, University of Mississippi Medical Center, Jackson, MS.

There are many causes of postoperative, recurrent peptic ulcer disease, among which are incomplete vagotomy, inadequate gastric resection, retained gastric antrum, inadequate drainage procedure and the Zollinger-Ellison syndrome. The diagnosis is suggested by the return of symptoms similar to those experienced before the first operation, says the author. He discusses factors in pathogenesis, diagnosis, differential diagnosis and treatment.

Diagnosis. Recurrent ulceration is frequently heralded by the onset of epigastric pain. The pain is often described as being very similar to that experienced before surgery. It is usually temporarily relieved by antacids. The pain and dyspepsia may be nocturnal. The most common complication of recurrent peptic ulcer disease is hemorrhage, occuring in approximately 60 per cent of cases.[1] The bleeding is not often found to be massive, presenting most often as anemia or melena. Nausea, vomiting and weight loss, signifying some degree of obstruction, is observed in approximately one half of these patients. Perforation of recurrent ulcers is the least often occurring complication, but when it does occur, the manifestations are those usually seen following disruption of the upper alimentary tract.

Gastric analysis and the Hollander test may provide valuable information in assessing the possible presence of recurrent ulcer disease. An accurate evaluation of gastric acid levels is sometimes difficult to accomplish. Destruction of the pyloric valve mechanism with abetment of alkaline reflux along with rapid exit of gastric secretions from the stomach impairs the reliability of resulting data. Nevertheless,

if maximal histamine-stimulated acid output is more than 15 per cent mEq/hr, then the presence of recurrent peptic disease can be strongly suspected. Conversely, histamine-fast achlorhydria virtually excludes anastomotic ulcer. Inordinately high gastric acid levels are suggestive of the Zollinger-Ellison syndrome or possibly, retained gastric antrum.

CAUSES OF RECURRENT PEPTIC ULCER

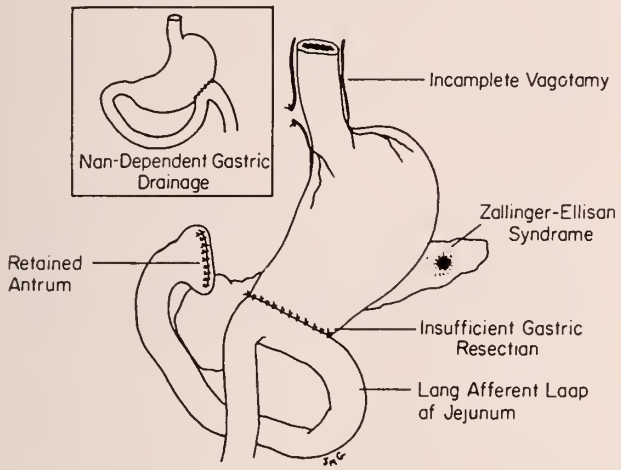


Figure 1. Some factors involved in postoperative peptic ulceration.

Radiology represents an enormously valuable and reliable method of evaluating the intact stomach and duodenum for peptic disease. Unfortunately the creation of an artificial stoma with anastomotic niches and folds greatly impairs the accuracy of radiologic assessment. The procedure can provide valuable information and should be done if accompanied by a realization of its limitations (see Figure 2).

Gastroscopy represents a very useful approach to the diagnosis of anastomotic peptic disease. Many of the ulcers are superficial and can be demonstrated only by this method. The procedure is accompanied by little risk, but many pitfalls exist for the unexperienced and occasional endoscopist. Interpretation of the significance of the many folds, nitches and surgically created abberations in the vicinity of the stoma represents an ever present threat for the minimally trained viewer.

Differential Diagnosis. There are, of course, several different pathophysiological mechanisms which may be responsible for abdominal problems during the late postoperative course following gastric surgery. Accurate differentiation must be achieved in order to apply the necessary, specific therapy. Reflux gastritis may produce epigastric pain, but this discomfort is described as being different from that experienced before surgery, where recurrent ulceration is appreciated as the same type of pain. The reflux gastritis patient would also exhibit a hypo- to achlorhydria and the gastroscopic findings would be different. The early dumping syndrome is characterized by bloating and abdominal cramps, but not true pain. The late dumping syndrome would not likely be confused with recurrent ulceration. Other conditions which merit consideration include the small gastric pouch problems and the chronic afferent loop syndrome.

Treatment. The medical management of recurrent ulcer disease is essentially the same as for primary peptic ulcer problems. A small percentage will respond satisfactorily and can be managed for an indefinite period. The majority of patients with recurrent ulcer will necessitate surgical intervention. This is because the original circumstances which rendered the condition refractory to medical management are probably still in existence. Additionally, the various causes which were recorded above can usually be expected to yield satisfactory correction only after surgical management. It is probable that a marginal ulcer sufficiently deep to be visualized on x-ray should be treated surgically from the beginning.



Figure 2. Recurrent ulcer resulting from incomplete vagotomy.

Complicated cases which exhibit hemorrhage, perforation or obstruction merit early surgical intervention. The operative procedure appropriate for the intractable, recurrent ulcer relates considerably to the previous operation. In general terms, a vagotomy should be added if this was omitted from the first procedure. Following limited gastric resection, removal of stomach tissue may be extended. Retained antrum must be searched for and excluded. Also, the presence of the Zollinger-Ellison syndrome must be considered and the second operation should not be concluded without providing dependent gastric drainage.[2] Rarely, a total gastrectomy will be in order.

SUMMARY

There are many causes of postoperative, recurrent peptic ulcer disease, among which are incomplete vagotomy, inadequate gastric resection, retained gastric antrum, inadequate drainage procedure and the Zollinger-Ellison syndrome. The diagnosis is suggested by the return of symptoms similar to those experienced before the first operation. Additional evidence can be gained by gastroscopic examination but radiologic examination can be expected to provide a low yield. Medical management should be tried in all cases; however, the number of patients successfully managed by this approach has been relatively small. Surgical intervention is indicated in the majority of incidences. The specific operation for a given case depends upon several factors, among which are the type of surgical procedure initially employed, the level of gastric acid production, the body habitus of the patient and the number of previous abdominal operations. ★★★

2500 North State Street (39216)

REFERENCES

1. Johnson, D. P. and Ferris, D. O. Diagnosis of Stomal Ulceration. Surg. Clin. N. Amer. 51:871, 1971.
2. Lindenauer, S. M. and Dent, T. L. Management of the Recurrent Ulcer. Arch. Surg. 110:531, 1975.

1776/1976

On the two hundredth anniversary of the founding of the United States of America, it is appropriate to reprint what is inscribed on the Statue of Liberty which was a gift from France to the United States in celebration of our first hundred years.

THE NEW COLOSSUS

Not like the brazen giant of Greek fame,
With conquering limbs astride
from land to land;
Here, at our sea-washed,
sunset gates shall stand
A mighty woman with a torch,
whose flame
Is the imprisoned lightning,
and her name
Mother of exiles.
From her beacon-hand
Glows world-wide welcome;
her mild eyes command
The air-bridged harbor that
twin cities frame.
"Keep ancient lands, your storied
pomp!" cries she
With silent lips. "Give me your
tired, your poor,
Your huddled masses yearning to
breathe free,
The wretched refuse of your
teeming shore.
Send these, the homeless,
tempest-tost to me.
I lift my lamp beside the golden door!"

Emma Lazarus

Radiologic Seminar CLXI: Intravenous Voiding Cystourethrography

DAN T. KEEL, M.D.
Brookhaven, Mississippi

INTRAVENOUS voiding cystourethrography (IVVCU) is a simple, noninvasive method of examining the urethra. Performance of the study following high dosage intravenous urography produces satisfactory visualization of the urethra in a high percentage of cases without requiring catheterization or direct retrograde filling of the urethra. The urethra is visualized during its normal voiding sequence and errors due to instrumentation are avoided.

IVVCU is not satisfactory for demonstrating vesico-ureteral reflux since the ureters and kidney collecting systems contain contrast material from the preceding intravenous urogram. The quality of the study is occasionally limited due to the diminished density of the contrast material as compared to direct filling methods. For satisfactory study the patient must be of sufficient age and temperament to cooperate with the examination. The examination should not be performed with every intravenous urogram due to the increased radiation exposure to the patient.

IVVCU is performed almost exclusively in male patients and is of particular value in screening young boys for urethral anomalies. These abnormalities occur only very rarely in girls in whom they are better excluded by other methods. Urethral stricture, fistula, diverticulum, traumatic injuries, benign prostatic enlargement and carcinoma of the prostate with urethral invasion may also be visualized by this method.

The examination is performed by allowing the bladder to fill with contrast material following high dosage intravenous urography. A prevoiding filled bladder radiograph and a standing oblique scout radiograph including all of the urethra and bladder are obtained and viewed to establish a satisfactory technique. Technical factors of this film should include kilovoltage in the 70-75 KV range with high milliamperage and as short an exposure time as possible to stop motion during voiding.

The patient is then asked to void into a plastic urinal and a film is exposed during voiding. He is asked to interrupt voiding if possible and a second film is obtained during a second voiding episode. A post voiding bladder film is then obtained. If the patient has difficulty voiding, liberal oral fluids are given and he is asked to sit and wait in the radiology department until he feels that he can void.

Preferably, the examination is performed under fluoroscopic monitoring with rapid serial filming utilizing the 105 mm spot film camera. The latter method is the one now used since this allows up to 6 films per second during the voiding sequence and does not require interruption of voiding.

If a female patient is to be examined, it is best to film the urethra in the straight lateral projection with the thighs flexed to about 90 degrees.

Case No. 1—A 14-year-old healthy, mildly obese, white male complained of slightly slow urinary stream of long duration and several recent episodes of gross blood from the penis spotting the underwear. There was no history of urethral trauma or urinary tract infection. A drip infusion urogram showed the upper urinary tracts to be normal. There was slight dilation of the urinary bladder. Following the urogram IVVCU revealed dilation of the prostatic and membranous urethra with a short, tight stricturing of the proximal bulbar urethra. The urethra distal to the stricture appeared normal.

The stricture was dilated endoscopically with immediate improvement of symptoms. No urethral valves were identified. He is to be followed with serial IVVCU examinations to exclude recurrence. (Please see photo on the next page.)

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Kings' Daughters Hospital, Brookhaven, MS.



Figure 1. Case No. I—IVVCU showing dilation of the prostatic and membranous urethra with a short tight stricture of the proximal bulbar urethra.

Case No. II—A 19-year-old very obese white male presented with complaints of difficult voiding and dry ejaculation. He gave a history of having a "bladder neck revision" prior to age 1. Retrograde ejaculation was established by the presence of sperm in the urine following ejaculation. A drip infusion urogram demonstrated the upper urinary tracts to be normal. IVVCU revealed a funnel shaped bladder neck, prostatic and membranous urethra with a 2 cm. tight stricture of the bulbar urethra and slight post stenotic dilation of the urethra. He denied any previous infection or trauma other than the previous surgery. Dilation of the stricture produced improvement in the voiding difficulty but did not correct retrograde ejaculation. He will be followed closely with serial radiographic examinations and may well require a urethroplasty in the future.



Figure 2. Case No. II—IVVCU showing funnel appearance and dilation of the bladder neck, prostatic and membranous urethra. There is a 2 cm. tight stricture of the bulbar urethra with post stenotic dilatation.

SUMMARY

Intravenous voiding cystourethrography is a simple, rapid, noninvasive technique for examining the urethra in a variety of conditions. It eliminates the need for more complicated studies in many cases. ★★★

P.O. Box 764, 39601

DEFINITION

"Shrink-resistant" doesn't mean that it won't shrink; it means that it will shrink but it doesn't want to.

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, June 26-July 1, Dallas. Clinical Convention, Dec. 4-8, 1976, Philadelphia. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

La.-Miss. O. and O. Society, April 28-May 1, 1977, Point Clear, Ala. Arthur Hays, M.D., Secy., 3017 13th St., Gulfport 39501.

STATE AND LOCAL

Mississippi Academy of Family Physicians, Annual Meeting, July 7-10, 1976, and July 6-9, 1977, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 109th Annual Session, May 2-5, 1977, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Smith, Yazoo.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Gerald A. Smith, Secy., P.O. Box 128, Sumner 38957. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. A. K. Martinolich, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Reginald P. White, Secy., East Mississippi State Hospital, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, April, June, August, October, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., Jefferson Davis Memorial Hospital, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. D. Stanley Hartness, Jr., Secy., 314 Adams St., Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Lee H. Rogers, Secy., 610 Brunson Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, October. Cherie Friedman, Secy., 1004 Jackson Ave., Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. James H. Sams, Secy., P.O. Box 1381, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, May, July, September, November. Dewey Laner, Secy., Doctors Plaza, Suite 206, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. John L. Smith, Secy., No. 1 Medical Blvd., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

When the same patient makes your office a merry-go-round of somatic complaints

I don't know how long it's been since I had a restful night's sleep.

My chest feels so tight—I just can't seem to breathe right.

Doctor, if I don't get rid of this pain in my stomach, I'm going to go crazy.



Adapin® (doxepin HCl) may be what she needs

I'm so jumpy, I'm afraid of my own shadow.

I have these headaches almost everyday—I can't understand it, I never used to have them.

Doctor, is it right that I should be so constipated all the time?



Anxiety/depression could be the basis of her somatic complaints
You know the type. She's got a new symptom every visit. And there's never any physiological basis. When you see the chronic "complainer," a diagnosis of depression may be considered... and an Rx for Adapin.

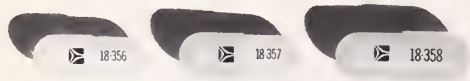
Adapin allays anxiety; improves sleep; brightens the outlook
Adapin can often help the chronic "complainers" get positively re-involved with life. Adapin almost immediately allays symptoms of anxiety and tension. And from the earliest days it makes it easier for the patient to get to sleep—helps her stay asleep longer. And where there is underlying depression, Adapin usually begins to lift it within three or four weeks.

Please see following page for prescribing information

ADAPIN®
(Doxepin HCl)
Capsules, 10 mg, 25 mg and 50 mg

PENNWALT

ADAPIN®
(Doxepin HCl)



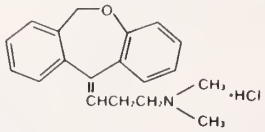
10 mg. **25 mg.** **50 mg.**

Usual optimum dosage is 75 to 150 mg. per day.

Prescribing information:

DESCRIPTION

Adapin (doxepin HCl) is an isomeric mixture of N, N-dimethyl-dibenz(b,e) oxepin- $\Delta^{11(6H)}$, γ propylamine hydrochloride.



ACTIONS

Adapin has a variety of pharmacological actions with its predominant action on the central nervous system. While its mechanism of action is not known, studies have demonstrated that it is neither a monoamine oxidase inhibitor nor a primary stimulant of the central nervous system.

INDICATIONS

In controlled clinical evaluations, **Adapin** has shown marked antianxiety and significant antidepressant effects. **Adapin** has been found to be well tolerated even in elderly patients.

Adapin is indicated for the treatment of patients with:

1. Psychoneurotic anxiety and/or depressive reactions.
2. Mixed symptoms of anxiety and depression.
3. Anxiety and/or depression associated with alcoholism.
4. Anxiety associated with organic disease.
5. Psychotic depressive disorders including involutional depression and manic-depressive reactions.

Target symptoms of psychoneurosis that respond particularly well to **Adapin** include: anxiety, tension, depression, somatic symptoms and concerns, insomnia, guilt, lack of energy, fear, apprehension and worry.

Because **Adapin** provides antidepressant as well as antianxiety effects, it is of particular value in patients in whom anxiety masks depression. Patients who have not responded to other antianxiety or antidepressant drugs may benefit from **Adapin.**

In a large series of patients systematically observed for withdrawal symptoms, none were reported—a finding which is consistent with the virtual absence of euphoria as a side effect and the lack of addictive potential characteristic of this type of chemical compound.

CONTRAINDICATIONS

Because **Adapin** has an anticholinergic effect, it is contraindicated in patients with glaucoma or a tendency toward urinary retention.

Use of **Adapin** is contraindicated in patients who have been found hypersensitive to it.

WARNINGS

Usage in Pregnancy—Adapin has not been evaluated in pregnant patients. Therefore, it should not be used during pregnancy unless, in the judgment of the physician, it is essential to the welfare of the patient.

In animal reproduction studies of **Adapin,** gross and microscopic examination of the offspring gave no evidence of drug-related teratogenic effect. Following doses of up to 25 mg./kg./day for 8 to 9 months, no changes were observed in the number of live births, litter size, or lactation. A decreased rate of conception was observed when male rats were given 25 mg./kg./day for prolonged periods—an effect which has occurred with other psychotropic drugs and has been attributed to drug effect on the central and/or autonomic nervous systems.

Usage in Children—The use of **Adapin** in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors—Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with **Adapin.** The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

PRECAUTIONS

Drowsiness may occur with **Adapin (doxepin HCl);** therefore, patients should be warned of its possible occurrence and cautioned against driving a motor vehicle or operating hazardous machinery while taking the drug.

Patients should also be cautioned that the effects of alcoholic beverages may be increased.

Since suicide is an inherent risk in depressed patients and remains a risk through the initial phases of improvement, depressed patients should be closely supervised.

Although **Adapin** has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Compounds structurally related to **Adapin** can block the effects of guanethidine and similarly acting compounds. However, at the usual clinical dosages, 75 mg. to 150 mg. per day, **Adapin** has been given concomitantly with guanethidine without blocking its antihypertensive effect. But at dosages of 300 mg. per day or higher, **Adapin** has exerted a significant blocking effect.

Adapin, like other structurally related psychotropic drugs, potentiates norepinephrine response in animals. But this effect has not been observed with **Adapin** in humans, which is in accord with the low incidence of tachycardia reported clinically.

ADVERSE REACTIONS

Anticholinergic Effects: Dry mouth, blurred vision and constipation have been reported. These are usually mild, and often subside as therapy is continued or dosage reduced.

Central Nervous System Effects: Drowsiness has been observed. It usually occurs early in the course of therapy and tends to subside as therapy continues. (See Dosage and Administration section.)

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported adverse effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects (such as increased sweating), weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

DOSAGE AND ADMINISTRATION

In most patients with mild to moderate anxiety and/or depression: 10 mg. to 25 mg. t.i.d. to start. A starting dosage of 10 mg. t.i.d. for a period of four days may reduce the initial drowsiness experienced by some patients, and may be tried in cases where drowsiness is clinically undesirable. Decrease or increase the dosage at appropriate intervals according to individual response. Usual optimum dosage is 75 mg. to 150 mg. per day.

In some patients with mild symptomatology or emotional symptoms accompanying organic disease, dosage as low as 25 mg. to 50 mg. per day has provided effective control.

In more severe anxiety and/or depression: 50 mg. t.i.d. may be required to start—if necessary, gradually increase to 300 mg. per day. Additional effectiveness is rarely obtained by exceeding 300 mg. per day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

OVERDOSAGE

Symptoms—An increase of any of the reported adverse reactions, primarily excessive sedation and anticholinergic effects such as blurred vision and dry mouth. Other effects may be: pronounced tachycardia, hypotension and extrapyramidal symptoms.

Treatment—Essentially symptomatic; supportive therapy in the case of hypotension and excessive sedation.

HOW SUPPLIED

Each capsule contains doxepin, as the hydrochloride: 10 mg. (NDC 0018-0356), 25 mg. (NDC 0018-0357) and 50 mg. (NDC 0018-0358) capsules in bottles of 100, and 1000.

Brighter days ahead for your psychosomatic complainers



PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603

Address of the President

JACK A. ATKINSON, M.D.
Brookhaven, Mississippi

As we gather during the bicentennial year of this great nation of ours, I believe it is only fitting that we pause and reflect on how very fortunate we are. We have much for which to be thankful!

History recalls for us a description of the medical treatment given to the first president of our country. George Washington was taken ill suddenly, gasping for breath with what must have been edema of the larynx. He was purged, emetics were given, leeches were applied to his throat, and then he was bled. He died shortly thereafter.

Many great men of science have come and gone since Mr. Washington was treated with the best that medicine had to offer. Today, we are blessed with a rich heritage of scientific knowledge and technology which enables us not only to save more lives but also to help provide a better quality of life for many of our patients.

Medicine has not been the only beneficiary of progress in this great nation of ours. Think if you will for a moment of what has occurred in transportation, communication and every other area of our lives.

In the words of the economist, Kenneth Boulding, "The world of today is as different from the world in which I was born as that world was from the day of Julius Caesar, almost as much has happened since I was born as happened before." The practice of medicine has not been immune to the enormous pressures of change, and I believe the profession has adjusted remarkably well. This does not mean, however, that most of us are not concerned about the direction in which we are moving. We are concerned about the increasing involvement of the federal government in health care. We are concerned with national health legislation which stretches rationality to the limit.

We must be responsive, however, to the public's concern and desire for quality health care at a reasonable cost, and we must continue to more effectively address this issue as a profession.

Total health care expenditures amounted to some $118 billion in this country last year. This was 8 per cent of the market value of all goods and services produced in the country during the year. In 1950 expenditures were $10.4 billion or 4.6 per cent of the gross national product. In Mississippi the Medicaid program alone cost some $110 million during fiscal year 1975. During its first full year of operation, which was fiscal year 1971, the program cost $40 million.

The federal government's own publications cite the fact that about one half the increase in the country's medical care bill between 1950 and 1975 was due to inflation. Such an outcome is inevitable when the money available to pay for a product or service is increasing faster than the supply of that product or service. Programs such as Medicare and Medicaid, as well as the growth in private insurance have stimulated demand for health services faster than the available supply of such services.

I was glad to see the AMA compose a Commission on the Cost of Medical Care. The commission will no doubt bring much useful information to the profession and to the public concerning health care costs. Such information is needed and should be well publicized to both the profession and the public.

In looking to the future, we must continue to address the so-called shortage in health resources. This is particularly true in regard to primary care specialties. Last year 58 per cent of all graduating medical students entered the primary care specialties. This more than exceeded the AMA's goal of 50 per cent and compares to 38 per cent of the students entering these specialties in 1968.

In Mississippi we have about one physician per 1100 population. This compares to a national average of one physician per 550 population. Statistically, we have about the same situation with other health professional groups. We do need more physicians, particularly physicians in the primary care specialties.

On the other side of the coin, however, we should keep in mind that Mississippi is a relatively sparsely populated state. There are many areas of the state where we do not need more health manpower and resources but rather better coordination, on an area basis, of the resources that are available. I speak here of such things as inter-community provision of emergency services which one community by itself

---

President, Mississippi State Medical Association. Read before the House of Delegates, 108th Annual Session, Jackson, May 3, 1976.

might not be able to adequately provide but several communities working together can provide very adequately.

We must also give our medical center the support it needs to train doctors, dentists, nurses and other health professionals. The University of Mississippi Medical Center will meet our state's needs for health manpower based on the financial support the people of Mississippi are willing to give the school through their elected representatives. This is an annual problem and we must ask ourselves where on the list of state funding priorities do we place funding for training health personnel. I think it should be somewhere around the top.

We are addressing ourselves more to peer review as a means of assuring both the quality and efficiency of medical services. This can serve a useful purpose and I am happy to note that the medical profession in Mississippi has been among those in the forefront in this regard. High quality medical care at a reasonable cost should be our aim and I urge our continuing efforts to strengthen and support peer review mechanisms.

Medicine today is truly a lifetime of learning, and continuing medical education has become more and more a part of the daily life of each physician. I am happy to note that we have been in the forefront of those state medical associations organizing formal mechanisms to provide continuing medical education programs.

Two years ago this House of Delegates directed that a program be organized within the association to accredit CME programs for Mississippi physicians. Ours was among the first associations to organize such a program within guidelines of the AMA Council on Medical Education. The program is moving along and our MSMA Council on Medical Education will devote special effort this year to identify and accredit local CME programs. The council will also establish a mechanism for physicians to report CME credit to the state office which will be cumulated and annually reported back to them.

It is my recommendation that the association establish continuing medical education as a condition for continued membership beginning in 1978. The Council on Medical Education should be urged to present a detailed plan to implement this requirement to the 1977 meeting of the House of Delegates.

In summary, the public is concerned about the quality and cost of health care services. We should have no fear of this concern because it is also our concern.

I would now like to conclude my remarks by briefly reviewing some of the highlights of this past year as I have traveled over the state meeting with you and others on behalf of our profession.

Last year marked the beginning of the professional liability insurance crisis in Mississippi. I wish I could say it also marked its end. Through your excellent efforts we have made a beginning in resolving some aspects of the crisis legislatively. Also, the major carrier for this coverage in the state, which last year announced its departure if things did not get better, is still with us.

I believe the subject of professional liability insurance coverage is going to take our constant vigilance and efforts for the foreseeable future. Last year hospitals and physicans in this country paid $1.5 billion for liability insurance. This compares to $60 million in 1960. In Mississippi, premiums for physicians' liability coverage will almost double this year. I am told the situation for our hospitals is even worse.

I feel that over the past year we communicated with all concerned with the professional liability insurance crisis except perhaps our greatest ally—our patients—the public.

It is my recommendation that the association mount an extensive campaign over the next year to communicate the professional liability insurance crisis to the public and to seek the public's support of solutions to the crisis. Such a campaign should use all media, radio, television and newspapers. It should be funded by a special assessment from the membership based on its cost. And, I urge you not to be penny-wise and pound-foolish in this regard. The professional liability insurance crisis contains the seeds to destroy the practice of medicine as we know it today.

On another subject—last year the Mississippi Political Action Committee participated for the first time in races for state offices. Your interest, commitment and support to local candidates has given the profession a much stronger voice in the governmental process. The first health voting index on each member of our new legislative term will soon be in your hands. I urge you to discuss your legislator's voting record with him and to continue to support your Mississippi Medical Political Action Committee.

I wish to thank you for a very memorable year. Eleanor and I have enjoyed the opportunity to visit with you over the past year. Your hospitality, interest and support have made this a year we will never forget. ★★★

P.O. Box 379 (39601)

Syphilis—CDC Recommended Treatment Schedules, 1976

The following recommendations were established by the Venereal Disease Control Advisory Committee after deliberation with therapy experts.

Members of the Venereal Disease Advisory Committee were: R. H. Henderson, M.D., Chairman, Venereal Disease Control Div., Bur. of State Services, Center for Disease Control, Atlanta, GA; J. H. Miller, Executive Secretary, Venereal Disease Control Div., Bur. of State Services, CDC; D. Fouser, WNET-TV, New York City, NY; H. Hamilton, Editor, *Urban Health,* Atlanta, GA; G. H. Handy, M.D., Dept. of Health and Social Services, Madison, Wl; B. Krohn, Barbara Krohn and Associates, Seattle, WA; S. Nixon, M.D., Floresville, TX; M. O. Shinn, EOC of Imperial County (CA), Inc., El Centro, CA.

Therapy experts consulted were: V. Cave, M.D., Brooklyn, NY; P. E. Dans, M.D., University of Colorado Medical School, Denver, CO; N. J. Fiumara, M.D., State Dept. of Public Health, Boston, MA; A. R. Hinman, M.D., State Dept. of Public Health, Nashville, TN; R. H. Kampmeier, M.D., Central State Hospital, Nashville, TN; L. Klein, M.D., Grady Memorial Hospital, Atlanta, GA; W. Ledger, M.D., University of Southern California Medical Center, Los Angeles, CA; W. McCormack, M.D., Boston City Hospital, Boston, MA; G. McCracken, M.D., University of Texas Medical Center, Dallas, TX; N. B. Nichols, M.D., Universtiy of Oklahoma Health Sciences Center, Oklahoma City, OK; P. Perine, M.D., Virginia Mason Clinic, Seattle, WA; M. F. Rein, M.D., University of Virginia, Charlottesville, VA; J. P. Sanford, M.D., Uniformed Services University of the Health Sciences, Bethesda, MD; A. L. Schroeter, M.D., Mayo Clinic, Rochester, MN; P. F. Sparling, M.D., University of North Carolina, Chapel Hill, NC; L. Taber, M.D., Baylor College of Medicine, Houston, TX; E. C. Tramont, M.D., LTC, MC, Walter Reed Army Medical Center, Washington, DC.

Few data have been published on the treatment of syphilis since CDC revised these recommendations in 1968. Penicillin continues to be the drug of choice for all stages of syphilis. Every effort should be made to document penicillin allergy before choosing other antibiotics because these antibiotics have been studied less extensively than penicillin. Physicians are cautioned to use no less than the recommended dosages of antibiotics.

EARLY SYPHILIS

(Primary, secondary, latent syphilis of less than 1 year's duration)

1. Benzathine penicillin G—2.4 million units total by intramuscular injection at a single session. *Benzathine penicillin G is the drug of choice because it provides effective treatment in a single visit.* OR
2. Aqueous procaine penicillin G—4.8 million units total: 600,000 units by intramuscular injection daily for 8 days. OR
3. Procine penicillin G in oil with 2% aluminum monostearate (PAM)—4.8 million units total by intramuscular injection: 2.4 million units at first visit, and 1.2 million units at each of 2 subsequent visits 3 days apart. *Although PAM is used in other countries, it is no longer available in the United States.*

Patients who are allergic to penicillin:

1. Tetracycline hydrochloride*—500 mg. 4 times a day by mouth for 15 days. OR
2. Erythromycin (stearate, ethylsuccinate or base)—500 mg. 4 times a day by mouth for 15 days.

These antibiotics appear to be effective but have been evaluated less extensively than penicillin.

Reported by Venereal Disease Control Div. Bur. of State Services, CDC, Atlanta, Ga. 30333.
Italics indicate commentary.

* Food and some dairy products interfere with absorption. Oral forms of tetracycline should be given 1 hour before or 2 hours after meals.

SYPHILIS OF MORE THAN 1 YEAR'S DURATION

(Latent syphilis of indeterminate or more than 1 year's duration, cardiovascular, late benign, neurosyphilis)

1. Benzathine penicillin G—7.2 million units total: 2.4 million units by intramuscular injection weekly for 3 successive weeks. OR
2. Aqueous procaine penicillin G—9.0 million units total: 600,000 units by intramuscular injection daily for 15 days.

The optimal treatment schedules for syphilis of greater than 1 year's duration have been less well established than schedules for early syphilis. In general, syphilis of longer duration requires higher-dose therapy. Although therapy is recommended for established cardiovascular syphilis, there is little evidence that antibiotics reverse the pathology associated with this disease.

Cerebrospinal fluid (CSF) examination is mandatory in patients with suspected, symptomatic neurosyphilis. This examination is also desirable in other patients with syphilis of greater than 1 year's duration to exclude asymptomatic neurosyphilis.

Published studies show that a total dose of 6.0-9.0 million units of penicillin G results in a satisfactory clinical response in approximately 90% of patients with neurosyphilis. There is more published clinical experience with short-acting penicillin preparations than with benzathine penicillin G. Some clinicians prefer to hospitalize patients with neurosyphilis, particularly if the patient is symptomatic or has not responded to initial therapy. In these instances they treat patients with 12-24 million units of aqueous crystalline penicillin G given intravenously each day (2-4 million units every 4 hours) for 10 days.

Patients who are allergic to penicillin:

1. Tetracycline hydrochloride—500 mg. 4 times a day by mouth for 30 days. OR
2. Erythromycin (stearate, ethylsuccinate or base) —500 mg. 4 times a day by mouth for 30 days.

There are NO published clinical data which adequately document the efficacy of drugs other than penicillin for syphilis of more than 1 year's duration. Cerebrospinal fluid examinations are highly recommended before therapy with these regimens.

SYPHILIS IN PREGNANCY

Evaluation of pregnant women:

All pregnant women should have a nontreponemal serologic test for syphilis, such as the VDRL or RPR test, at the time of the first prenatal visit. The treponemal tests such as FTA-ABS test should not be used for routine screening. In women suspected of being at high risk for syphilis, a second nontreponemal test should be performed during the third trimester. Seroreactive patients should be expeditiously evaluated. This evaluation should include a history and physical examination, as well as a quantitative nontreponemal test and a confirmatory treponemal test.

If the FTA-ABS test is nonreactive and there is no clinical evidence of syphilis, treatment may be withheld. Both the quantitative nontreponemal test and the confirmatory test should be repeated within 4 weeks. If there is clinical or serologic evidence of syphilis or if the diagnosis of syphilis cannot be excluded with reasonable certainty, the patient should be treated as outlined below.

Patients for whom there is documentation of adequate treatment for syphilis in the past need not be retreated unless there is clinical or serologic evidence of reinfection such as darkfield-positive lesions or a 4-fold titer rise of a quantitative nontreponemal test.

A. For patients at all stages of pregnancy who are not allergic to penicillin: Penicillin in dosage schedules appropriate for the stage of syphilis as recommended for the treatment of nonpregnant patients.

B. For patients of all stages of pregnancy who are allergic to penicillin: Erythromycin (stearate, ethylsuccinate or base) in dosage schedules appropriate for the stage of syphilis, as recommended for the treatment of nonpregnant patients. Although these erythromycin schedules appear safe for mother and fetus, their efficacy is not well established. Therefore, the documentation of penicillin allergy is particularly important before treating a pregnant woman with erythromycin. *Erythromycin estolate and tetracycline are not recommended for syphilitic infections in pregnant women because of potential adverse effects on mother and fetus.*

Follow-up:

Pregnant women who have been treated for syphilis should have monthly quantitative nontreponemal serologic tests for the remainder of the current pregnancy. Women who show a 4-fold rise in titer should be retreated. After delivery, follow-up is as outlined for nonpregnant patients.

CONGENITAL SYPHILIS

Congenital syphilis may occur if the mother has syphilis during pregnancy. If the mother has received adequate penicillin treatment during pregnancy, the risk to the infant is minimal. However, all infants should be examined carefully at birth and at frequent intervals thereafter until nontreponemal serologic tests are negative.

Infected infants are frequently asymptomatic at birth and may be seronegative if the maternal infection occurred late in gestation. Infants should be treated at birth if maternal treatment was inadequate, unknown, with drugs other than penicillin, or if adequate follow-up of the infant cannot be ensured.

Infants with congenital syphilis should have a CSF examination before treatment.

Infants with abnormal CSF:

1. Aqueous crystalline penicillin G, 50,000 units/kg. intramuscularly or intravenously daily in 2 divided doses for a minimum of 10 days. OR
2. Aqueous procaine penicillin G, 50,000 units/kg. intramuscularly daily for a minimum of 10 days.

Infants with normal CSF:

Benzathine penicillin G, 50,000 units/kg. intramuscularly in a single dose. *Although benzathine penicillin has been previously recommended and widely used, published clinical data on its efficacy in congenital neurosyphilis are lacking. If neurosyphilis cannot be excluded, the procaine or aqueous penicillin regimens are recommended. Since cerebrospinal fluid concentrations of penicillin achieved after benzathine penicillin are minimal to nonexistent, these revised recommendations seem more conservative and appropriate until clinical data on the efficacy of benzathine penicillin can be accumulated. Other antibiotics are not recommended for neonatal congenital syphilis.*

Penicillin therapy for congenital syphilis after the neonatal period should be with the same dosages used for neonatal congenital syphilis. For larger children the total dose of penicillin need not exceed the dosage used in adult syphilis of more than 1 year's duration. After the neonatal period, the dosage of erythromycin and tetracycline for congenital syphilitics who are allergic to penicillin should be individualized but need not exceed dosages used in adult syphilis of more than 1 year's duration. Tetracycline should not be given to children less than 8 years of age.

FOLLOW-UP AND RETREATMENT

All patients with early syphilis and congenital syphilis should be encouraged to return for repeat quantitative nontreponemal tests 3, 6, and 12 months after treatment. Patients with syphilis of more than 1 year's duration should also have a repeat serologic test 24 months after treatment. Careful follow-up serologic testing is particularly important in patients treated with antibiotics other than penicillin. Examination of CSF should be planned as part of the last follow-up visit after treatment with alternative antibiotics.

All patients with neurosyphilis must be carefully followed with serologic testing for at least 3 years. In addition, follow-up of these patients should include clinical reevaluation at 6-month intervals and repeat CSF examinations, particularly in patients treated with alternative antibiotics.

The possibility of reinfection should always be considered when retreating patients with early syphilis. A CSF examination should be performed before retreatment unless reinfection and a diagnosis of early syphilis can be established.

Retreatment should be considered when:

1. Clinical signs or symptoms of syphilis persist or recur;
2. There is a sustained 4-fold increase in the titer of an nontreponemal test;
3. An initially high-titer nontreponemal test fails to show a 4-fold decrease within a year.

Patients should be retreated with the schedules recommended for syphilis of more than 1 year's duration. In general, only 1 retreatment course is indicated because patients may maintain stable, low titers of nontreponemal tests or have irreversible anatomical damage.

EPIDEMIOLOGIC TREATMENT

Patients who have been exposed to infectious syphilis within the preceding 3 months and other patients who on epidemiologic grounds are at high risk for syphilis should be treated as for early syphilis. Every effort should be made to establish a diagnosis in these cases.

The American Red Cross maintains a computerized Rare Blood Donor Registry that enables it to locate donors quickly to provide uncommon blood types whenever and wherever needed.



The President Speaking

"Objectives of Medical Injury Compensation System"

LYNE S. GAMBLE, M.D.
Greenville, Mississippi

AT OUR RECENT annual session, a resolution was introduced by Dr. William E. Godfrey, II, Delegate, Adams County, providing that the Mississippi State Medical Association initiate an indepth study of the cost and benefits of a patient compensation program for medical injuries similar to the present Workman's Compensation program. The resolution was favorably reported by the reference committee and was passed by the House of Delegates. The following information is contained in a document entitled "Objectives of Medical Injury Compensation System" prepared by Richard Bergen, AMA Office of the General Counsel.

Objective: *"To provide compensation to a greater but not unlimited, number of patients who have suffered some substantial injury in the course of their medical care.* Under the present tort liability system, at least 60 per cent of those who make claims receive nothing and those that do, receive no more than 16 to 25 per cent of the insurance cost of the system. Under the present, and far from perfect, Workman's Compensation system, at least 60 per cent of the insurance cost is received by claimants as compensation.

Objective: *"To provide predictability of the frequency of claims by providing definite objective standards for determining eligibility for compensation benefits.* Under the present tort liability system, the frequency of claims is unpredictable because the standards for determining liability are so indefinite, subjective and flexible that liability is more a matter of chance than of realistic appraisal. Under the present far from perfect, Workman's Compensation system, the frequency of claims is much more accurately predictable.

Objective: *"To provide predictability of average cost and total cost of compensation benefits by establishing realistic, definite, objective standards for compensation payable for particular injuries.* Under the present tort liability system, damage awards are totally unpredictable because they are based on indefinite, subjective standards left to the virtually unlimited discretion of a jury. Under the present far from perfect, Workman's Compensation system, scheduled benefits under definite, objective standards make average and total cost of compensation reasonably predictable.

Objective: *"To provide unlimited future medical care to the extent necessitated by the compensable injury.* Under the present tort liability system the claimant may get nothing or may get money compensation to pay for future medical care which may be ex-

(Continued on page 195)

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XVII, NUMBER 7
JULY 1976

EDITORIALS

Postirradiation Carcinoma of The Thyroid Gland

In the early 1920's many infants and children received x-ray therapy for such conditions as enlarged thymus, hypertrophy of the tonsils and adenoids, cervical adenitis, sinusitis, and so forth. Unfortunately, the thyroid gland frequently received direct or scattered irradiation during these treatments. As the irradiated population has grown older it has become apparent that these people have an increased incidence of thyroid cancer. Recent publicity on this problem in the newspaper, radio, and television has alarmed individuals or their parents who in turn have consulted their physicians for advice.

All individuals with a history of head and neck irradiation should be considered as having an increased risk of developing thyroid cancer. These patients should be examined every two years indefinitely. Fortunately, only a small percentage of irradiated individuals develop thyroid tumors. Most of the tumors found have been benign. Those which are malignant have been well differentiated, papillary, or follicular neoplasms which grow slowly, metastasize relatively late, and are curable by surgical removal before metastasis has occurred.

If on palpation of the thyroid gland one or more firm, discrete nodules are palpated, these should be removed regardless of other findings. A scan may be useful in assessing the functional status of the nodule and may give some indication as to whether the nodule is malignant or benign.

If the scan shows a cold area which corresponds with a palpable mass, the patient should be considered for prompt surgical exploration. If the scan shows a hot nodule, it is usually not malignant, but should be closely observed for change.

GEORGE H. MARTIN, M.D.
Associate Editor
Vicksburg, MS

The President Speaking

(Continued)

cessive or inadequate. A lump sum damage award may be exhausted or wasted before a future need for medical care arises. Under the present far from perfect Workman's Compensation system, it provides at least to some extent, for continuing medical care to the extent necessitated by the compensable injury.

Objective: *To provide a procedure for determination of eligibility for compensation benefits and the amount of benefits with a minimum of complexity and formality so that most claims can be handled without adverse party litigation and without the necessity for representation by attorneys, so as to keep expense determination to a minimum.* Under the present tort liability system, a claim for damages immediately triggers an adversary party procedure, which requires representation by attorneys, does nothing to encourage prompt, reasonable settlement, and may often result in prolonged, complicated, and expensive litigation. Under the present less than perfect, Workman's Compensation system, some claims are handled without adversary party litigation but excessive litigation still occurs."

In view of the possibly disastrous consequences of the medical liability problem, it behooves us to consider every possible solution to every facet of the problem. A "patient compensation program" for medical injuries similar to the Workman's Compensation program may be the solution to the medical liability problem. ***

Medico-Legal Briefs

UPHOLD VALIDITY OF MEDICAL MALPRACTICE PANELS IN N. Y.

A state law authorizing three-man medical malpractice panels to submit recommendations to a jury is constitutional, a New York appellate court ruled.

A 37-year-old woman had been going to an obstetrician-gynecologist for ten years. He had delivered all four of her children and had examined the patient routinely at regular intervals. When the patient complained of a swelling in her right breast, the physician diagnosed the condition as post-ovulatory swelling and prescribed a diuretic. As the condition worsened during the next two months, the physician continued the original treatment, dismissing the possibility of a tumor. A month later the condition was diagnosed as cancer. During the next 18 months, the patient underwent two radical mastectomies, an ovariectomy, massive cobalt treatments and debilitating chemotherapy because of the metastasis of the cancer.

The patient brought suit against the physician. In accordance with the new malpractice law, the case was presented to a malpractice panel. The panel unanimously agreed that the physician had been negligent, but the parties could not agree on a settlement. The case then went to trial, and the panel's recommendation was introduced into evidence. The jury returned a verdict for the patient for $175,000 and the physician appealed.

Challenging the constitutionality of the malpractice panels, the physician argued that it interfered with the jury's prerogative to decide issues of fact. The court rejected the physician's argument. The court reviewed the background of the malpractice problem and said that the legislature had acted properly in enacting the measure.

Referring to the state's no-fault automobile insurance law, the court said a similar challenge to it had been rejected by the highest court of New York.

The recommendation of a malpractice panel was not binding on a jury, the court noted. The law was a reasonable necessity and was not unconstitutional. The jury's verdict was affirmed.—*Halpern v. Gozan, New York Law Journal,* Feb. 10, 1976 (N.Y.Sup. Ct., Feb. 1976)

LETTERS

SIRS: According to *Newsweek,* Mar. 24, 1975, dogbites have reached epidemic proportions in the United States. A 5-year-old boy was playing in his backyard when 3 dogs (2 collies and a Labrador retriever) loped by. The boy ran to the animals, and for a moment 1 of them licked his hand. Then, as the boy's mother watched from the kitchen window, the dogs attacked the boy in snarling rage, mauling and biting his head, neck, and arms. After the dogs had fled, the mother rushed the boy to the hospital, but he died in the emergency room from shock and a loss of blood.

The boy was the victim of what public health officials regard as a major, but largely unrecognized, epidemic. For the period 1960-1970, the number of dogbites reported rose alarmingly in the United States. In St. Louis and Washington, D.C., the rate doubled. In Baltimore it went up 74 per cent and in New York City 58 per cent.

Six dogbite-associated deaths were reported to the Center for Disease Control in 1974. Health authorities estimate that about 1 million persons are bitten by dogs each year. The cost of treating dogbites runs to $50 million a year, and dogbites are rivaled by only gonorrhea for the top position among reported diseases and injuries.

Dr. Alan Beck of New York City's Bureau of Animal Affairs, who is convinced that statistics obtained from a study he conducted in St. Louis apply throughout the country, found that 60 per cent of dogbites involve children under 15 years of age. Nearly 40 per cent of pre-school children are bitten on the head or neck, largely because they are at eye level with larger breeds. However, for all age groups about 50 per cent of dogbites are on the legs, 28 per cent on arms and hands, and 13 per cent on the body.

Although the last death in the U.S. caused by rabies from a dogbite occurred more than a decade ago, many victims still receive antirabies treatment, with its dangers of side effects.

Contrary to popular belief, only a small propor-

tion of bites are inflicted by ownerless strays. More than 85 per cent of dogbites involve privately owned dogs, and nearly half occur within 1 block of the owner's home. Dr. Beck theorizes that a dog's sense of territoriality plays a large part in the dogbite situation. The area in which a dog is habitually allowed to run comes to be regarded as its territory. Only 2 per cent of bites are the result of deliberate provocation.

Health authorities think the dramatic increase in dogbites can be attributed to the growing popularity of large dogs, which are often purchased for protection in the large cities, rather than an increase in the dog population.

To curb the dogbite epidemic, Dr. Beck says owners should keep their dogs leashed or at home.

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health

NEW MEMBERS

BARRETT, H. S., JR., Gulfport. Born Atlanta, GA, Jan. 31, 1939; M.D., University of Tennessee College of Medicine, Memphis, TN, 1966; interned San Diego County University Hospital, San Diego, CA, one year; radiology residency, Charity Hospital, New Orleans, LA, 1969-1972; elected by Coast Counties Medical Society.

FOX, CLAUDE EARL, III, Tupelo. Born Charleston, MS, Nov. 8, 1946; M.D., University of Mississippi School of Medicine, Jackson, MS, 1972; interned in pediatrics, University Medical Center, Jackson, one year; Master of Public Health, University of North Carolina, Chapel Hill, NC, 1974-75; elected by Northeast Mississippi Medical Society.

MEYER, WILLIAM H., McComb. Born Jackson, MS, April 18, 1941; M.D., University of Mississippi School of Medicine, Jackson, MS, 1967; interned Mobile General Hospital, one year; orthopaedic surgery residency, University Medical Center, Jackson, MS, 1971-75; elected by South Central Medical Society.

PYRON, KATHARINE A., Gulfport. Born Kansas City, MO, Oct. 2, 1942; M.D., University of Missouri School of Medicine, Columbia, MO, 1968; interned University of Missouri, Columbia, MO, one year; internal medicine residency, same, 1969-71; elected by South Mississippi Medical Society.

SEAY, JOHN DAVID, Amory. Born Fairfield, AL, May 28, 1942; M.D., Medical College of Alabama, Birmingham, AL, 1969; interned St. Vincent's Hospital, Birmingham, AL, one year; ob-gyn residency, University of South Alabama, Mobile General Hospital, Mobile, AL, 1972-75; elected by Northeast Mississippi Medical Society.

DEATHS

DENSON, GROVER C., Long Beach. Born Silver Creek, MS, Aug. 5, 1884; M.D., University of Tennessee College of Medicine, Nashville, TN, 1907; interned Charity Hospital, Vicksburg, MS, one year; Fifty Year Club MSMA; Emeritus member of MSMA and AMA; died April 11, 1976, age 92.

MOSLEY, ELMER W., Biloxi. Born Iberia, MO, July 14, 1886; M.D., University of Illinois College of Medicine, Chicago, IL, 1911; interned Evangelical Deaconess Hospital, Chicago, IL, one year; Fifty Year Club MSMA; died May 22, 1976, age 89.

PERSONALS

RICHARD L. BLOUNT of Jackson is serving as chief of staff of St. Dominic Hospital. Other new staff officers are THOMAS C. TURNER, chief-elect; JAMES N. MCLEOD, secretary; PAUL GOODE, chief of general practice; and LEWIS D. LIPSCOMB, chief of ob-gyn.

JOHN F. BUSEY of Jackson is the author of "Modern Concepts in the Diagnosis and Management of the Pulmonary Mycoses" in *Clinical Notes on Respiratory Diseases* which is published quarterly by the American Thoracic Society. Dr. Busey is serving as 2nd vice president of the Mississippi Lung Association.

EVERETT CRAWFORD, WALTER CRAWFORD, BEN CRAWFORD, JAMES MCLAIN, KANTA BUTANI and P. S. GANARAJ, all of Tylertown, have moved into their new office building, the Walthall Medical Complex which is located next to Walthall County General Hospital.

YONG-MIN CHI, formerly of Delhi, NY, has set up his practice of general surgery at 1000 Fifth Avenue in Picayune.

PERSONALS / Continued

The Mississippi Health Systems Agency, Inc., has announced that the following physicians have been elected to its Board of Directors: J. T. Davis, Corinth; A. B. Britton, Jr., Jackson; Howard Clark, Morton; and Charles A. Bush, Waynesboro.

J. F. Eckford of Starkville related highlights of his 50 years of medical practice at the first annual dinner meeting of the Oktibbeha County Historical and Genealogical Society.

Lyne S. Gamble of Greenville, MSMA president, was featured speaker at the state meeting of the American Association of Medical Assistants, Mississippi chapter, in Tupelo.

A. Van Dyke Hagaman and William L. Hughes of Jackson were both honored at the 50th anniversary of their graduating classes. Dr. Hagaman is an alumnus of the University of Mississippi and Dr. Hughes of the University of Virginia.

W. L. Jaquith of Jackson was guest speaker at the meeting of the Jackson County Association for Mental Health in Pascagoula.

Charles R. Jenkins of Laurel has been nominated by the Board of Directors of the Mississippi chapter for election to the American Academy of Family Physicians Board of Directors. The election will be held Sept. 20 in Boston.

W. F. McDonnell, Jr., of Gulfport served as fleet surgeon for the 28th annual Mississippi Deep Sea Fishing Rodeo at the Gulfport Small Craft Harbor July 1-5.

J. Daniel Mitchell of Jackson has been invited to serve as a member of the Committee on Physicians, American Hospital Association and was appointed to the editorial advisory board of *Hospital Medical Staff*, which has a circulation of 21,000.

Ed North of Jackson, a national director of the Exchange Club, delivered the dedicatory address and presented, on behalf of the McComb Exchange Club, a Freedom Shrine exhibit to Parklane Academy.

Jo N. Robinson of Columbus has been elected to the Columbus City Council.

Donald M. Sherline of Jackson and UMC is among producers of the award winning film "Resuscitation of the Newborn," chosen best of the year during the American College of Obstetricians and Gynecologists meeting in Dallas.

McKamy Smith of Jackson was a participant in the scientific session of the Alabama Heart Association in Birmingham. He spoke on clinical and hemodynamic features of cardiogenic shock.

Perrin Smith of Columbus spoke on problems and problem solving at the meeting of the Prairie chapter of the American Association of Medical Assistants in Columbus.

Ray Stewart of Gulfport has been named by Harrison County supervisors to replace C. D. Taylor of Pass Christian as the county physician. Upon accepting Dr. Taylor's resignation, the board of supervisors passed a resolution commending him for his long service to the county.

Tate Thigpen of Jackson and UMC has been elected vice chairman of the Hinds County chapter of the American Red Cross.

Dennis I. Wright of Meridian has been elected to fellowship in the American Academy of Pediatrics.

W. D. Young has associated with the Vicksburg Clinic in the department of surgery.

PSRO Receives Good Report

The Administration has submitted an "encouraging report" to Congress on the Professional Standards Review Organizations (PSRO) program, but confessed at the same time that lawmakers should not expect too much in the way of cost savings.

Louis Hellman, M.D., head of the Health Services Administration, recently told the House Ways and Means Oversight Subcommittee that "important progress has been made." He said in the 203 designated PSRO areas there are 65 conditional organizations performing review and another 55 in the planning stage. By the end of the fiscal year, 120 conditional PSROs will be in operation reviewing some 3 million hospital admissions, he said. More than 106,000 physicians are now members of organized PSROs according to the Heath, Education and Welfare Department official.

Dr. Hellman said the primary purpose of the PSRO program is quality assurance and that cost-effectiveness was a secondary objective. "The quality assurance activities of PSROs may increase the utilization of some services while decreasing that of others," he testified as— "a word of caution on expectations of a PSRO's ability to control expenditures."

Book Reviews

Correlative Neuroanatomy and Functional Neurology. 16th edition. 448 pages. By J. G. Chusid. Los Altos, California: Lange, 1976. $10.00.

This new edition of the popular paperback volume by Dr. Chusid retains its customary form. A tremendous amount of information about the nervous system is condensed into readable short paragraphs, outlines and tables. Perhaps the most instructive portion of this book continues to be the set of illustrations and diagrams which number in the hundreds.

Although intended for the "beginner in clinical neurology" it contains material far beyond the beginner's level as well. Neuroanatomy is reviewed in detail and applied to the neurologic examination. A condensed review of central nervous system disorders rounds out the work.

Attractive features include concise summaries of the paraneurologic exams such as audiometry, psychometrics, cystometrics, etc.

The information presented here is quite current in thc clinical areas. Some relatively useless material from earlier days has been retained, such as Ayala's index and the many vague synonyms for brain stem vascular syndromes.

In general, this is an excellent book for students and practitioners who wish to refresh their knowledge of the neurosciences.

A. F. Haerer, M.D.
Jackson, MS

Hypnosis in the Relief of Pain. By Earnest R. Hilgard, Ph.D. and Josephine R. Hilgard, M.D. 262 pages with illustrations. Los Altos, California: William Kaufmann, Inc., 1975. $12.50.

The authors of this book are well known in the fields of psychiatry and psychology. I consider this work to be of importance to physicians and others who are interested in the relief of pain and suffering. They discuss some theories of pain and pain perception. In our medical training, most of us have had some exposure to hypnotic techniques but few have taken the time to develop these skills. In our drug oriented society, to have available for practical consideration an alternative means of pain and suffering reduction is valuable.

The authors present their important research carried out in their research laboratory and document the important usefulness of hypnosis in clinical practice.

Thc modern approach to hypnosis is individualized with care being given to the special needs of the patient and with increased emphasis on teaching of self-hypnosis.

In the sections on specific uses of hypnosis in obstetrics, surgery, dentistry and cancer, specific hypnotic techniques are detailed with additional references in the notes in each chapter.

In the appendix of the book, the Hilgards give a protocol for administering the Stanford Hypnotic Clinical Scale which consists of an induction techniquc with specific tasks including post-hypnotic suggestion and amnesia.

Hopefully, the reading of this important work will stimulate many physicians to develop skills and to upgrade skills in hypnotic techniques that are appropriate and revelant to each practitioner's area of medical competence.

C. Duane Burgess, M.D.
Hattiesburg, MS

In Appreciation

The many fine technical exhibitors who participated in the exhibit during the recent Mississippi State Medical Association 108th Annual Session are deserving of our recognition and a hearty "Thank You!" Not only did the presence of these exhibits enhance the educational quality of our meeting, but the support provided by our exhibitors is essential to the continuance of our traditionally outstanding scientific program.

The firms listed below participated in our 1976 annual meeting exhibit and we voice a collective expression of our sincere appreciation. May we also suggest that you retain this listing and express your personal appreciation when their representatives call upon you.

Alza Pharmaceuticals, Palo Alto, CA
Ames Co., Div. of Miles Labs, Elkhart, IN
Bedsole Surgical Supply Co., Inc., Mobile, AL
Blue Cross-Blue Shield of MS, Inc., Jackson, MS
Boehringer Ingelheim Ltd., Elmsford, NY
Bristol Laboratories, Syracuse, NY
Ciba Pharmaceuticals, Summit, NJ
Cooper Laboratories, Inc., Parsippany, NJ
Danal Laboratories, St. Louis, MO
Data Professional Corp., Jackson, MS
Deposit Guaranty National Bank, Trust Division, Jackson, MS
Dista Products, Indianapolis, IN
Jasper Ewing and Sons, Inc., Jackson, MS
First Investment Co., Jackson, MS
First National Bank of Jackson, Jackson, MS
General Medical-Jackson, Jackson, MS
Hill Crest Hospital, Birmingham, AL
Hoechst-Roussel Pharmaceuticals, Inc., Somerville, NJ
Kremers-Urban Co., Milwaukee, WI
Lanier Business Products, Jackson, MS
Mallinckrodt, Inc., Hazelwood, MO
Roger McGehee Travel Agency, Jackson, MS
McNeil Laboratories, Ft. Washington, PA
Medical and Corporate Financial, Inc., Jackson, MS
Meyer Laboratories, Inc., Ft. Lauderdale, FL
Pfizer Laboratories, Doraville, GA
W. P. Poythress and Co., Richmond, VA
Professional Asso. Lab., Inc., Jackson, MS
Riverside Hospital, Jackson, MS
A. H. Robins Co., Richmond, VA
Roche Laboratories, Nutley, NJ
Safeguard Business Systems, Tucker, GA
Sandoz Pharmaceuticals, East Hanover, NJ
Schering Corp., Kenilworth, NJ
E. R. Squibb and Sons, Princeton, NJ
St. Paul Fire and Marine Insurance Co., St. Paul, MN
Systemedics/AMS, Laurel, MS
The Travelers Insurance Co.-Medicare, Jackson, MS
UAD Laboratories, Inc., Jackson, MS
U.S. Air Force, New Orleans, LA
USV Pharmaceuticals Corp., Tuckahoe, NY
Unifirst Federal Savings and Loan Assoc., Jackson, MS
Warren-Teed Pharmaceuticals, Pearl, MS
Weight Watchers in Greater MS, Jackson, MS

Scientific Grants Were Received From

A. H. Robins Company
Eli Lilly and Company
Schering Laboratories
Geigy Pharmaceuticals
Merck, Sharp and Dohme
Ross Laboratories
Flint Laboratories
Heyer-Schulte

POSTGRADUATE CALENDAR

FUTURE CALENDAR

September 16-17, 1976

GENETICS COURSE

October 4-8

FAMILY MEDICINE REVIEW

October 11-15

EKG INTENSIVE COURSE

October 25-29

HEMATOLOGY/ONCOLOGY INTENSIVE COURSE

November 4-5

ARRHYTHMIA WORKSHOP FOR PHYSICIANS

November 8-12

NEPHROLOGY INTENSIVE COURSE

November 15-17

UROLOGY INTENSIVE COURSE

December 2-3

INFECTIOUS DISEASES INTENSIVE COURSE

May 2-5, 1977

MISSISSIPPI STATE MEDICAL ASSOCIATION, BILOXI

The University of Mississippi Medical Center Division of Continuing Health Professional Education offers intensive refresher courses to meet physicians' clinical practice needs in the specialties most requested. Mississippi Regional Medical Program partially supports the series, open to all physicians. Intensive courses are eligible for AMA Physician Recognition Award Category I credit. Enrollment is limited, and applications are accepted in the order received. All correspondence about intensive and other courses should be addressed to Continuing Health Professional Education, University Medical Center, 2500 North State Street, Jackson, MS 39216.

Health Planning Potpourri

Two private Mississippi nonprofit corporations, the Mississippi Health Systems Agency, Inc. and the Mississippi Health Improvement Corporation submitted new applications in June for funding as the state's Health System Agency (HSA) under Public Law 93-641. H.E.W. has announced plans to conclude the latest funding cycle for HSA's by early August.

Both MHSA's and MHIC's applications were rejected by H.E.W. during the last HSA funding cycle. Governor Finch has endorsed MHSA's application.

Considerable controversy has arisen around implementation of Public Law 93-641 in Mississippi. Former Governor Waller had endorsed MHIC's application prior to leaving office. Efforts to statutorily designate a State Planning and Development Agency called for by Public Law 93-641 failed during the 1976 Regular Session of the Mississippi Legislature.

At the recent MSMA 108th Annual Session, the House of Delegates was highly critical of the conduct of the MHSA in organizing as the Health Systems Agency for Mississippi. In a strongly worded resolution the House called for better organization of health system areas in Mississippi to include the state being designated as three or more health system areas. The House also directed the Board to seek legal action, if advisable, with respect to the manner the MHSA was implementing Public Law 93-641.

The MSMA Board of Trustees has formally protested the application of the MHSA for funding as the Health Systems Agency for Mississippi with both the governor and the Department of H.E.W. The Board is also presently considering possible legal action against MHSA.

In other action dealing with designation of State Planning and Development Agencies under requirements of Public Law 93-641, H.E.W. has announced preliminary data which indicates that 25 of the selected agencies will be state health departments, 18 will be departments of human resources and the remainder will be located in the state's governor's office or some other state agency. Since the Mississippi Legislature failed to statutorily designate any state agency as the State Planning and Development Agency during its recent session, Governor Finch by executive order has designated his own Office of Comprehensive Health Planning as the agency.

Meanwhile, on the national level the AMA has filed a petition to become a co-plaintiff with the State of North Carolina in a suit to test the constitutionality of Public Law 93-641. In another action the National Association of Regional Councils, a Washington-based organization of local government councils, has also filed a lawsuit challenging the Public Law 93-641 as "an intolerable intrusion on state sovereignty."

Medical Center Awards 115 M.D. Degrees

Chancellor Porter L. Fortune, Jr., conferred degrees on 115 University of Mississippi School of Medicine graduates in May 30 Commencement ceremonies.

Speaker for the exercises, the Medical Center's 20th Commencement, was Dr. William H. Stewart, Louisiana's commissioner of health and human resources administration and a former surgeon general of the United States Public Health Service.

Dr. Stewart urged UMC graduates to help maintain balance in applying special knowledge and skills in caring for the sick "without being overwhelmed by specialism."

"Specialism is essential," he said, but he called for more "generalists" who'll act as hubs for the medical care wheel.

"Our problem is that we are creating more and more spokes in this field without the organizing effect of a center hub," Dr. Stewart said. "To the patient, health care . . . looks like a vast field of disorganized entities without a road map or guide to satisfy his needs."

Dr. Stewart said the key question of who will be the "general manager" from those who seek health care may be answered by the family physician. Since family medicine was reorganized as a specialty in

1969, he said residency training positions for the specialty have grown to a number equal to 10 per cent of the nation's medical school graduates.

"If this growth continues," he said, ". . . the movement in family practice may be the answer to the challenge of specialism."

The 222 UMC graduates this year included the medical degree candidates, 50 who got the B.S. in nursing, 11 a master of nursing, 21 the B.S. in physical therapy, and 14 who received a PhD. and 11 a master of science in the health sciences.

Summa cum laude graduate Edward Harris Holmes of Clarksdale got the University's Leathers Award as the graduating medical student with the highest academic average. An Ole Miss alumnus, Dr. Holmes will intern at University Hospital in Jackson.

Another medical school graduate, Maecenas Benton Hendrix, III, became the first in UMC Commencement history to get both the M.D. and the Ph.D. degree in anatomy at the same time. A Jackson native, he will do a surgery residency at the Fitzsimons Army Medical Center in Denver, CO.

Chancellor Fortune also presented citations to two retiring members of the UMC faculty, Dr. Louis L. Sulya, professor of biochemistry and chairman of the department, and Dr. James R. Dawson, professor of pathology.

UMC Graduate Gets Two Degrees



Dr. Maecenas Benton Hendrix, III, of Jackson received both the M.D. and Ph.D. during University of Mississippi Medical Center Commencement exercises. UMC Vice Chancellor Dr. Norman C. Nelson, right, congratulated the double graduate and his wife Adrian after the ceremony in city auditorium.

Dr. Holmes Is Top UMC Med Student



Dr. Edward Harris Holmes of Clarksdale, center, received the coveted Waller S. Leathers Award during University of Mississippi Medical Center Commencement exercises in Jackson. The award goes annually to the graduating medical student with the highest four-year academic average. University of Mississippi Chancellor Porter L. Fortune, Jr., left, conferred degrees on 222 UMC students. Dr. William Huffman Stewart, right, Louisiana Health and Human Resources Administration commissioner, addressed graduates at the 20th annual Commencement. Dr. Holmes, who will intern at University Hospital in Jackson, is the son of Mr. and Mrs. John B. Holmes of Clarksdale.

Prevent Blindness Society Reports on Year's Work

The Mississippi Society for the Prevention of Blindness screened 10,241 youngsters in its Preschool Vision Screening Program this past year according to the annual report issued through the office of Edith Mullin, executive director.

Of the 10,241 screened, 469 of these were referred to doctors for additional examination and treatment. The screenings were conducted by 618 volunteers who gave over 2,630 hours of their time.

In addition to the preschool vision activity, the society conducted glaucoma screenings at the Mississippi State Medical Association annual meeting, at five centers for senior citizens, and at a major industry in Jackson. A total of 193 individuals were screened, with 20 being referred to a doctor and three found to be positive.

The society also provided advice, support and materials for glaucoma screenings conducted by Lions Clubs throughout the state. The Lions and

MSPB have worked closely together through the years because of their common interest in sight conservation.

As part of its professional education program, the society sponsored a short course in "Tonometry for the Non-Ophthalmologist" at the Mississippi State Medical Association meeting. Postgraduate credit was given by the American Academy of Family Physicians.

Three registered nurses from Family Practice Center of the University Hospital were taught tonometry by Dr. Samuel Johnson, medical advisory committee chairman for the society. Preschool vision screening was also taught to classes of nurse practitioners at the University Medical Center, and the State Board of Health public health nurses requested screening training in their in-service workshops.

The MSPB safety program resulted in safety materials and posters being provided three major industries in the Jackson area, and 19 Wise Owl Clubs were formed, making 55 chapters in the state. Lions Clubs reported on enforcement of the School Eye Safety Law in their cities.

Funds for the work of the society were secured through a grant from the Junior League of Jackson, a Mint-Green Tea at the Governor's Mansion, through "Operation Jug" sponsored by the Beta Clubs, through canisters taken by 45 women's clubs and nine Y-Teen Clubs, and through voluntary contributions.

"Blindness can be prevented in many ways," said Harold Green of Jackson, society president, in thanking the volunteers and contributors. "It is our responsibility to find those ways and share the knowledge with all. With the continued interest and support of the public, 1976 can be a record year."

Contributions for prevention work can be mailed to the Society for the Prevention of Blindness, 115 Broadmoor Drive, Jackson, MS 39206.

Family Medicine Review Set

A seventh family medicine review, Session I—Sept. 26-Oct. 2, 1976, and Session II—Oct. 17-23, 1976, will be given at the University of Kentucky Medical Center in Lexington. Registration fee is $295.00.

For further information contact: Frank R. Lemon, M.D., Continuing Education, College of Medicine, University of Kentucky, Lexington, Ky. 40506.

Medicaid Announces Drug Cuts

In an announced effort to keep Medicaid expenditures within limits of available funds the Mississippi Medicaid Program initiated cuts in its covered drug program effective July 1, 1976. After that date Medicaid recipients will pay a 50 cent copayment on each prescription, peripheral vasodilators and anti-arthritic drugs will not be covered, and refills must be written.

Medicaid costs have risen from $40 million in 1971 to some $130 million projected for this fiscal year. Drugs are not a required service for Medicaid funding from the federal government.

Acute Pulmonary Medicine Featured



Ways to help patients with lung disease took first place among discussion topics at a University of Mississippi Medical Center workshop on acute pulmonary medicine. Faculty member Dr. Clyde Watkins of the Mississippi State Board of Health Tuberculosis Control Unit, left, joins participants, from second left, Dr. Gus Bynum of Hattiesburg, Dr. Enrique Fletchas of Natchez, and Dr. Preston S. Herring of Vicksburg. The Mississippi Thoracic Society, Mississippi Lung Association, and the UMC medical school and continuing education division sponsored the one-day session.

UMC Announces New Faculty Members

Two physicians are joining the University of Mississippi School of Medicine faculty this summer in key positions.

Dr. James Lee Achord took his post as professor of medicine and director of the Division of Gastroenterology June 1. Dr. James Bruce Pennebaker will come July 1 as assistant professor of medicine and director of the Division of Rheumatology.

Seven other faculty members joining the medical school include an associate professor, five assistant professors, and an instructor.

Vice Chancellor Dr. Norman C. Nelson announced the appointments after approval of the Board of Trustees, Institutions of Higher Learning.

Dr. Achord, former professor and associate dean for clinical affairs at East Tennessee State University, earned his M.D. degree at Emory University in 1956 and took housestaff training at Emory University Hospital.

Dr. Pennebaker is a 1969 graduate of the Mississippi medical school who interned and did a residency at University Hospital in Jackson. He is currently a fellow at the University of Texas Southwestern Medical Center.

Air Force Colonel Dr. Robert H. Edwards will come to UMC as an associate professor of pathology. With 20 years military service, he holds both the M.D. degree from Cornell University School of Medicine and the Ph.D. degree from the University of Wisconsin. Dr. Edwards interned at New York Hospital and did a residency at Presbyterian-St. Luke's Hospital in Chicago.

New assistant professors are Dr. Fred A. Crawford, Jr., surgery; Dr. Sydney Gordon Grant, family medicine; Dr. Frank A. Kulik, psychiatry and human behavior; Dr. Pauline Ting, pediatrics; and Dr. Jack Sidney Wilkinson, medicine (research). Dr. Jeffrey Allen Kelly will be an instructor in the psychiatry department.

A former U. S. Army major, Dr. Crawford got his medical degree, interned, and is completing a residency at Duke University School of Medicine.

Dr. Grant has been a family medicine practitioner in Fredericton, New Brunswick, Canada, since 1967. He holds the M.D. degree from Dalhousie University School of Medicine, where he interned.

Director of the alcoholism rehabilitation unit at Dunlap-Manhattan Psychiatric Center, New York, since 1974, Dr. Kulik holds the M.D. degree from the University of Maryland medical school. He interned at South Baltimore General Hospital and took residency training at Metropolitan Hospital Center, New York.

Dr. Ting, who served two years as associate director of the newborn nursery and neonatal intensive care unit at a California medical center, studied medicine in Burma and took her housestaff training in Baltimore and Chicago.

Dr. Wilkinson earned undergraduate and master's degrees at Louisiana State University and got his Ph.D. at Tufts University School of Medicine.

Completing an internship at University Hospital, Dr. Kelly holds Ph.D. and M.A. degrees from the University of Kentucky.

Principles of Ethics Permit Advertising

The Principles of Medical Ethics of the American Medical Association do *not* prohibit advertising by physicians, according to a recent statement by the AMA Judicial Council.

The public is entitled to know the names of physicians, the type of their practices, the location of their offices, their office hours, and "other useful information that will enable people to make a more informed choice of physician," the AMA council points out.

"The physician may furnish this information through the accepted local media of advertising or communication, which are open to all physicians on like conditions. Office signs, professional cards, dignified announcements, telephone directory listings, and reputable directories are examples of acceptable media for making information available to the public."

A physician may give biographical and other relevant data for listing in a reputable directory. The published data may include the charge for a standard office visit, or the doctor's fee or range of fees for specific types of services.

In the proscribed area of solicitation of patients, the council points out that it is unethical to use testimonials, create inflated or unjustified expectations of favorable results, make statements that are self-laudatory and imply that the physician has skills superior to others, or use incorrect or incomplete facts that are likely to cause the average person to misunderstand or be deceived.

Three UMC Med Students Study in Nepal

Three fourth-year medical students at the University of Mississippi Medical Center have been selected from nationwide competition to participate in a public health survey in Nepal, Asia.

Madena Gibson Whelan of Natchez and Robert Dean Culpepper and William Hubbard, both of Jackson, are in Nepal now observing health conditions.

The students are studying with Dr. Carl Taylor, one of the foremost authorities in public health in the United States. He is director of the division of international health at Johns Hopkins University School of Medicine in Baltimore, MD.

The expedition counts as a senior elective for which the students receive academic credit.

Ms. Whelan, the daughter of Mr. and Mrs. John C. Gibson, is a graduate of Delta State University. Culpepper, who received his undergraduate degree from the University of Southern Mississippi, is the son of Mr. and Mrs. Royce Leo Culpepper. Hubbard, the son of Mr. and Mrs. William James Hubbard, is a Millsaps alumnus.

Mammography Courses Are Offered

The University of Texas Cancer Center at Houston will offer a one week mammography training course the second or third week of each month. The courses began in May.

A maximum of four physicians and four technologists may register per course. Each course will be held Monday through Friday and eight hours of instruction will be given each day.

There is no fee and the course carries category 1 credit for AMA Physician's Recognition Award and American College of Radiology and is approved for ECE points by ASRT.

For information write Dawn N. Shull, Project Coordinator, Department of Diagnostic Radiology, M. D. Anderson Hospital and Tumor Institute, 6723 Bertner Drive, Houston, TX 77030.

Pulmonary Course Held at UMC



University of Mississippi Medical Center acute pulmonary medicine workshop participants Dr. Perrin Berry of Jackson, left, and Dr. Joe W. Terry, Jr., of Canton join seminar faculty members Dr. William C. Bailey, second right, and Dr. Ronald B. George. The UMC School of Medicine and continuing education division cosponsored the seminar with the Mississippi Thoracic Society and Mississippi Lung Association. Dr. George is professor of medicine and chief of pulmonary diseases at Louisiana State University School of Medicine, Shreveport, and Dr. Bailey is an associate professor of medicine and assistant dean for education at the University of Alabama School of Medicine, Birmingham.

it's the real thing

Enjoy Coca-Cola Trade-mark®

70-37

Mississippi Council of Coca-Cola Bottlers

Physicians Study Kidney Disease at UMC



Family physicians focused on latest techniques for treating kidney disease in a week-long intensive course at the University of Mississippi Medical Center in Jackson. Inspecting an artificial kidney are participants, from left, Dr. Gary Gordon of Meridian, seated, Dr. Marion V. Green of Holly Springs, and Dr. William F. Easley of Meridian. The UMC continuing education division sponsored the course with support from Mississippi Regional Medical Program.

Rocky Mountain Spotted Fever Update

Rocky Mountain spotted fever (RMSF), the only rickettsial disease causing significant mortality in the United States, is most common in the southeastern area of the country. Most cases occur during the spring and summer and are predominantly in children.

Through 1975, the rate in Mississippi (5 year average) was 17.6 cases per year, according to the State Board of Health.

RMSF is a tick-borne disease caused by *Rickettsia rickettsii*. The infection is maintained in nature through a cycle involving ticks and the animals they feed on. Man becomes an accidental victim of RMSF when he intrudes into the cycle and is bitten by an infected tick. An infected tick must have attached and been feeding for at least four to six hours, however, before rickettsias from the tick become reactivated and transmission can occur. Rickettsias from infected tick feces or juices can also gain access to the body through skin abrasions. Hence, crushing infected ticks can be hazardous.

The incubation time between tick bite and the onset of illness ranges from three to about ten days. Fever, headache, rash, mental confusion, and muscle aches are the principal clinical features of RMSF. The maculopapular and sometimes petechial rash, usually the earliest dependable diagnostic sign, tends to appear first on the wrists and ankles; it remains more marked on the extremities than on the trunk, and regularly involves the palms and soles.

A rising serum titer of complement-fixing antibody to *R. rickettsii* is diagnostic. The rise occurs in the second week of illness, or later if vigorous antibiotic therapy is given early. The Weil-Felix test for serum agglutinins to proteux OX-19 and OX-2 organisms is often not positive until late or not at all. Isolation of the rickettsial organism is hazardous and therefore not done routinely.

The overall mortality rate of untreated RMSF is 20 per cent; however, treatment with tetracyclines or chloramphenicol, when given early, is almost uniformly curative. Since serologic responses to the clinical infection of RMSF do not occur within the first week of illness and death usually occurs 7 to 14 days after onset of symptoms, physicians should not wait for a laboratory confirmation of the diagnosis to begin treatment, says Dr. Durward Blakey, director of the SBH Bureau of Disease Control.

RMSF vaccine is recommended for laboratory personnel working with *R. rickettsii* and possibly for persons whose occupations result in exposure to ticks in endemic areas. It is not recommended for use in the general population because the disease is uncommon and the vaccine is of limited effectiveness. RMSF vaccine usually does not prevent the disease but may reduce the severity of it.

Prevention of RMSF depends mainly on personal protection against ticks. Protective clothing and frequent examination of the body, especially the scalp, for ticks are recommended. Children especially should be inspected daily during the spring and sum-

mer months when the ticks are most active and exposure is most likely to occur. Use of a repellant containing diethyl-toluamide is also helpful. Pets, particularly dogs, should also be inspected daily.

Ticks found on a person or pet should be removed immediately. Avoid using bare fingers for removing ticks since an infected tick may transmit the disease by direct contact with abraded skin. Use tweezers or a folded piece of paper or cardboard and apply gentle but steady traction to remove the tick intact.

Insect Stings Can Be Fatal

It's that time of year again when most Americans are out of doors a lot. And it is that time of the year again when many Americans get stung.

Bees, yellow jackets, hornets, wasps and ants are the prime offenders in serious stings, says a special report in the May 31 issue of the *Journal of the American Medical Association.*

Claude A. Frazier, M.D., of Asheville, N. C., points out that an estimated eight in a thousand individuals are allergic to insect stings, and that four of these eight are severely sensitive.

"There are more fatalities annually due to insect stings or bites than to snakebites," says Dr. Frazier.

First aid for the severely allergic requires an immediate injection of epinephrine, and get the victim to a doctor or hospital fast.

Those known to be allergic to stings should be given desensitization injections to protect against the reaction in advance, he reminds.

Safest course is to avoid, as much as humanly possible, being stung in the first place.

Have all wasp nests around the house and yard destroyed.

Do not go barefoot or wear sandals outdoors from April to October.

Do not wear bright, flowery clothing. Bright colors attract bees especially.

Do not wear floppy clothing to entangle and madden insects.

Wear long pants, long-sleeved shirts, and gloves if working among flowers or fruits. Cover up.

Avoid wearing anything bright such as jewelry or buckles.

Do not use scented lotions, soaps, shampoos or perfumes.

Wear light colors such as white, light green, tan, and khaki.

If a bee or wasp comes near, do not swat. Retreat slowly. If retreat is impossible, lie face down and cover head with arms.

Cancer Concepts 1976 Set for October

The East Tennessee Cancer Research Center, Knoxville Academy of Medicine and University of Tennessee Center for the Health Sciences/Knoxville are presenting a workshop entitled "Cancer Concepts 1976" on Oct. 18-20, 1976, in Gatlinburg, TN.

The workshop, which will include oncologists as faculty, will attempt to provide the family practitioner and general surgeon with a practical overview of the latest diagnostic and treatment techniques for malignant neoplasms. Using three types of cancers as focal points: breast, lung, and gastrointestinal; topics such as xeromammography, sputum cytology, hormone receptors and adjuvant therapy will be explored. Sessions are planned for the morning only so that physicians and their families will have time to enjoy the resort area.

For more information, write the East Tennessee Cancer Research Center, Box 65, 1924 Alcoa Highway, Knoxville, TN 37920.

PRINTING — OFFICE SUPPLIES

EQUIPMENT — FURNITURE



Premier Printing Company

2485 West Capitol Jackson, Mississippi

Phone 352-4091

Medical Center Hosts Kidney Seminar



Guest faculty member Dr. Jay J. Gillenwater, second right, talks with Mississippi physicians at the 10th annual University of Mississippi Medical Center kidney disease seminar. Participants included, from left, Dr. Luke Platt of Tupelo, Dr. William Gates of Columbus, and Dr. Stanley A. Wade, Jr., of Meridian. Dr. Gillenwater is professor of urology and chairman of the department at the University of Virginia School of Medicine. The Mississippi medical school Departments of Medicine, Surgery (Urology), and Pediatrics and the Medical Center continuing education division cosponsored the session with the Kidney Foundation of Mississippi.

Interstate Scientific Assembly Scheduled

The 61st Annual International Scientific Assembly of Interstate Postgraduate Medical Association will be held at the Atlanta Marriott Hotel, Nov. 15-18, 1976. This program is designed for primary care physicians practicing in the U. S. and Canada and has been planned cooperatively with the Georgia Academy of Family Practice, the Emory University School of Medicine and the Medical College of Georgia.

The course provides 21 hours of prescribed and 3 elective hours of credit for members of the American Academy of Family Physicians. A similar number of hours of credit toward the AMA Physician's Recognition Award is provided through attendance.

The program consists of lectures, informal group discussions, "live" closed-circuit TV and medical movies on a variety of topics with major emphasis in family practice, internal medicine, obstetrics and gynecology and psychiatry. Guest lecturers include: Drs. Irvine Page and Ray Gifford of the Cleveland Clinic on "Hypertension." Dr. Lloyd Nyhus of Chicago speaking on "An In-Depth View of the Vagi" and Dr. Tague Chisholm of Minneapolis on "Pediatric Abdominal Pain." In addition there will be over 20 other lecturers from Georgia and the program will feature current information from the Center for Disease Control. The Thursday session will be devoted entirely to an "Update on Current Treatment."

The assembly is open to any licensed physician in the U. S. and Canada at a fee of $50.00 in advance or $75.00 at the meeting. Those interested in the meeting and hotel forms should write to: Alton Ochsner, M.D., Program Chairman, Interstate Postgraduate Medical Association, P. O. Box 1109, Madison, WI 53701.

UMC Faculty Member Coauthors Book

Dr. Richard C. Boronow, UMC professor of ob-gyn and director of the gynecologic tumor service, is one of three authors of a new volume on *Gynecologic Oncology*.

Coauthors are Dr. Felix Rutledge and Dr. J. Taylor Wharton, both of the University of Texas System Cancer Center, M. D. Anderson Hospital and Tumor Institute, Texas Medical Center, Houston. Publisher is John Wiley & Sons.

The book is a collection of lectures the authors have presented as a postgraduate course on gynecologic cancer and presents an overall view of the management of gynecologic oncology.

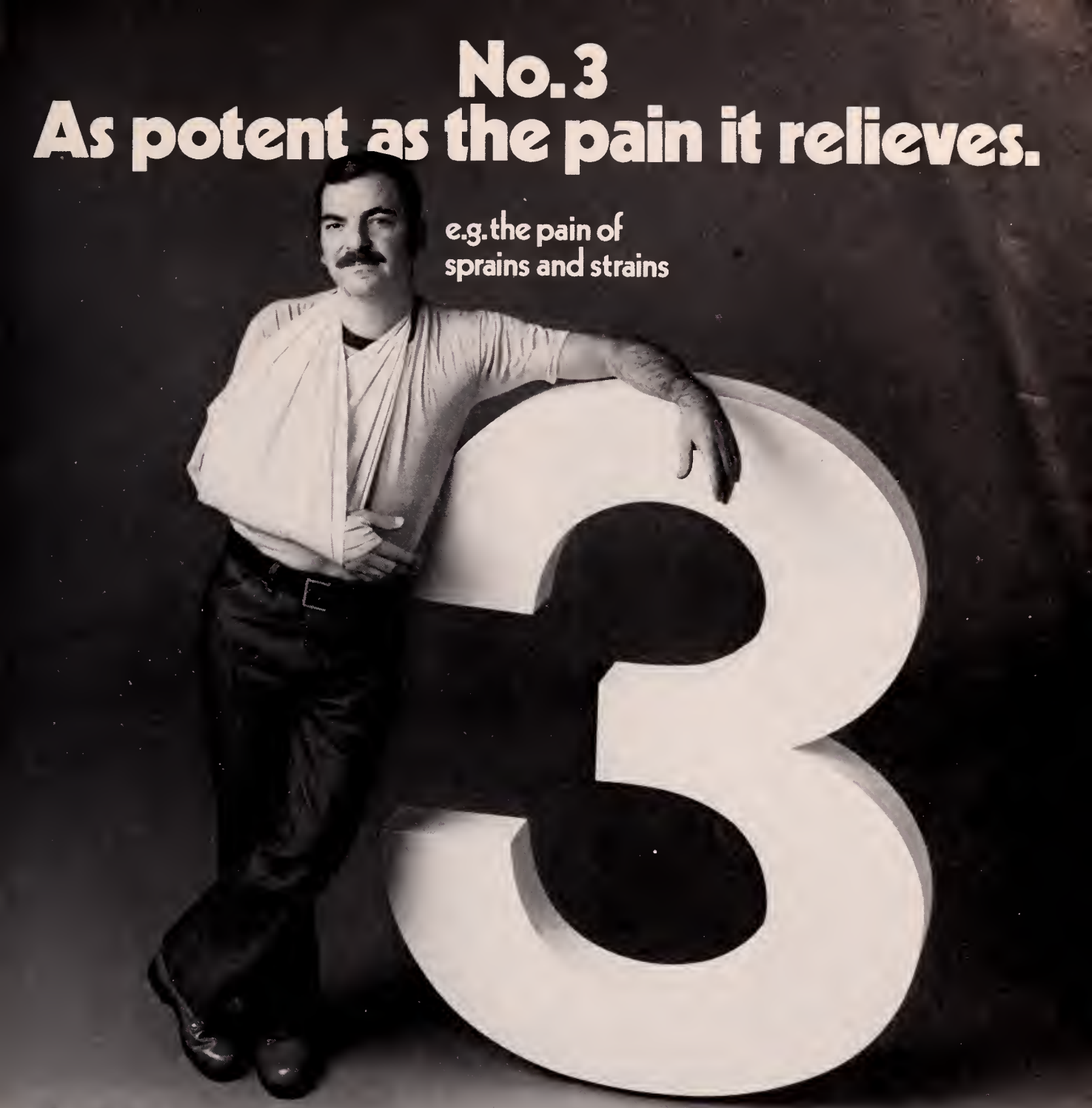
Echocardiography Course Planned

"Pediatric and Adolescent Echocardiography Course—Update '76" will be presented on Nov. 13-14, 1976 (the two days preceding the American Heart Association meeting) in Miami Beach, FL.

The course is sponsored by the American Society of Echocardiography and the Postgraduate Educational Division of H.E.L.P. and is approved for Category I continuing-education credit by the American Medical Association.

Further information may be obtained from course director Stanley J. Goldberg, M.D., The University of Arizona, 1501 N. Campbell, Tucson, AR 85724 (602/882-6508).

No. 3
As potent as the pain it relieves.



NOT TOO LITTLE
- as potent as the pain you need to relieve in patients with fractures, sprains, strains, wounds, contusions, and the pain of surgical convalescence
- unlike acetaminophen/codeine combinations, it does not sacrifice anti-inflammatory action

NOT TOO MUCH
- potent—yet not excessive
- addiction liability low

NOT TOO EXPENSIVE
- brand-name quality, yet reasonable in cost
- readily available in both hospital and local pharmacies

CIII CONVENIENCE
- telephone Rx in most states, up to 5 refills in 6 months at your discretion (where state law permits)

EMPIRIN® COMPOUND WITH CODEINE NO. 3

codeine phosphate* (32.4 mg) gr ½
Each tablet also contains: aspirin gr 3½, phenacetin gr 2½, caffeine gr ½. *Warning—may be habit-forming

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Counsel to Authors

THE JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, Miss. 39216, in original and at least one duplicate copy. They must be typewritten double spaced on 8½ by 11-inch white bond paper with a standard typewriter.

The author is responsible for all statements made in his work, including changes made by the manuscript editor. Manuscripts are received with the understanding that they are not under simultaneous consideration by any other publication and have not been previously published. All manuscripts will be acknowledged, and while those rejected are generally returned to the author, the JOURNAL is not responsible in event of loss. Manuscripts accepted for publication become the property of the JOURNAL and are copyrighted by the association when published. They may not be published elsewhere without written release and permission from both the JOURNAL and the author.

All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus,* volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made after proof sheets are received by the JOURNAL.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for illustration engravings not exceeding four column inches per printed page.

Illustrations must be numbered and cited in the text. Legends, not exceeding 40 words and preferably shorter, must accompany each illustration, typed double spaced on separate sheets. The following information should appear on a gummed label affixed to the back of each illustration: Figure number, manuscript title, author's name, and arrow indicating top of the illustration.

In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

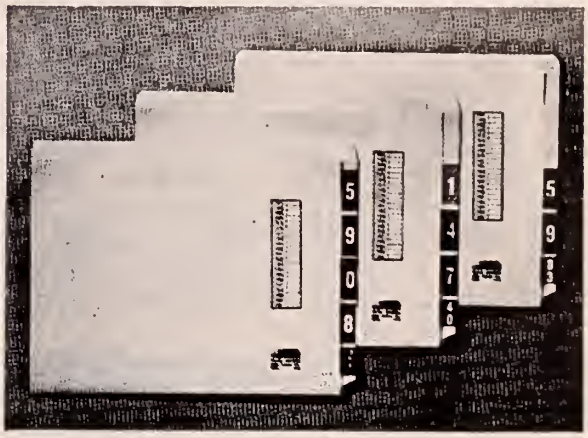
A thesis summary of 75 to 100 words must accompany each manuscript separately from the text.

Reprints may be obtained at cost plus shipping charges from the association and should be ordered prior to publication. The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. —*The Editors.*

JOIN MPAC TODAY

WHY OUR COLOR CODED
FILING SYSTEM?

REDUCES FILING TIME
ELIMINATES MIS-FILES
NO NEED TO REPLACE YOUR PRESENT FOLDERS



PRINTING — OFFICE DESIGN, FURNITURE & SUPPLIES

Mississippi Stationery Company
277 East Pearl Street — Jackson, Mississippi 39201

FOR MORE INFORMATION
CALL COLLECT (601) 354-3436

Index to Advertisers

Blue Cross and Blue Shield of Mississippi 12
Burroughs Wellcome Co. 209

Canton Exchange Bank 4
Coca-Cola 205

Hill Crest Hospital 14
Hyrex-Key Pharmaceuticals 17

Key Pharmaceuticals 15

Eli Lilly and Co. . . . . front cover

Mead Johnson Laboratories 18
Mississippi Stationery Co. 19

Pennwalt Prescription Products 188B, 188C, 188D
Pharmaceutical Manufacturers Assoc. 6, 7
Practice Productivity, Inc. 16
Premier Printing Co. 207

Roche Laboratories
. . . . . second cover, 3, 10, 10A, third ond fourth covers
Roerig and Co. 10D, 11

Smith Kline and French 10B

The Upjohn Co. 10C

Thomas Yates and Co. 8

IN CONCLUSION

The dramatic health progress since 1776 is outlined in "200 Years of Health and Medicine in the United States," published by Metropolitan Life Insurance Company. The colorful Bicentennial wall chart, 38 inches by 26 inches, is available free of charge to individuals, schools, hospitals and libraries throughout the country through Metropolitan's district offices or from the Health and Welfare Division, Metropolitan Life Insurance Company, One Madison Avenue, New York, NY 10010. The chart was designed to provoke awareness in personal health and safety.

An American Cancer Society survey on smoking by females shows that cigarette smoking has increased by five per cent since 1969 among teenage girls and that many in this group feel that their doctors have not warned them against smoking. According to the ACS study, 27 per cent of teenage girls now smoke as compared to 22 per cent in 1969. ACS also estimates that there would be 18,600 deaths from lung cancer in women in 1976 which is more than their combined estimate for deaths from cervical and corpus uteri cancer.

In 1974, the Minnesota State Pharmaceutical Association organized a comprehensive program to help pharmacists educate their patients in the proper use of drugs. The major component of the program is a series of instructional sheets for the patient. The instructions are written for classes of drugs (e.g. penicillins, narcotic analgesics, tetracyclines) and are designed to complement the pharmacist's verbal instructions and the prescription label. Besides aiding in compliance, the program combats medication errors and drug toxicity.

The impact of four national health insurance proposals on different income groups is analyzed in a Rand Corporation report published in Science magazine. The article, "The Financing of National Health Insurance," compares the Administration's CHIP, the Kennedy-Mills compromise bill of 1974, the current Kennedy-Corman measure, and the Long-Ribicoff catastrophic-type proposal. According to the article, the impact on families earning more than $9,000 a year would not vary much under the four plans.

The American Medical Association has endorsed 11 separate federal medical programs and has urged increased funding. The medical association has recommended more money for: Health Manpower Assistance; The Food and Drug Administration; National Institutes of Health; Emergency Medical Services Programs; Indian Health Programs; Immunization Programs; Venereal Disease Programs; Alcohol, Drug Abuse and Mental Health; Lead-based Paint Poisoning Prevention; and Family Planning. AMA pointed to the long-range impacts of a reduction in funding on the health of the population.

THE ANXIETY-SPECIFIC.

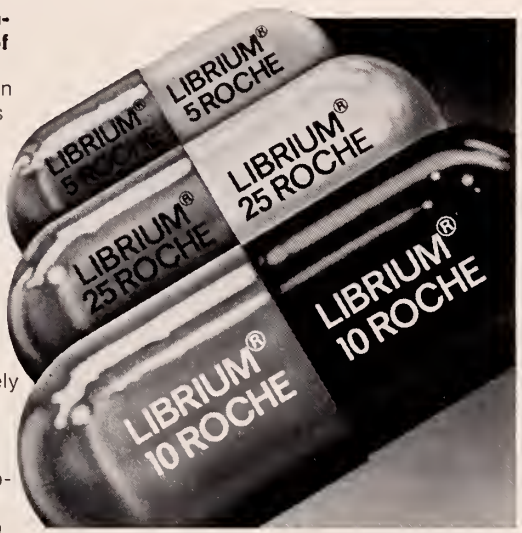
- a predictable pattern of patient response
- seldom associated with serious side effects, in proper dosage
- rarely interferes with mental acuity
- used concomitantly with many primary medications
- three dosage strengths meet most patient needs

LIBRIUM® ℞

chlordiazepoxide HCl/Roche

5 mg, 10 mg, 25 mg capsules

Libritabs® (chlordiazepoxide) available in 5 mg, 10 mg and 25 mg tablets.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido —all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.;* severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see following page.

THE ANXIETY-SPECIFIC

Since its discovery in the research laboratories at Roche, Libri has been the object of ongoing pharmacologic and clinical investigatio

The published record on Librium is enormous. So large, in fact, put it into a computer literature retrieval system to make it more accessible in answering your inquiries.*

It's a record that reveals a consistent pattern of patient response. A highly favorable benefits-to-risk ratio. And minimal interference with many primary medications.

Doing one thing well. Basically, that's what Librium is all about.

LIBRIUM® ℞
chlordiazepoxide HCl/Roche

LIBRARY
JUL 19 1976
NEW YORK ACADEMY OF MEDICINE



ROCHE

*If you have a question about Librium or any other Roche product, write to Professional Services, Roche Laboratories, Nutley, New Jersey 07110.

Please see preceding page for a summary of product information.

2EAST 103RD ST
NEW YORK N.Y.
1C029

BALCONY

JOURNAL OF THE Mississippi STATE MEDICAL ASSOCIATION

AUGUST 1976

New from Lilly/Dista Research

NALFON®
fenoprofen calcium
300-mg.* Pulvules®

DISTA
Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

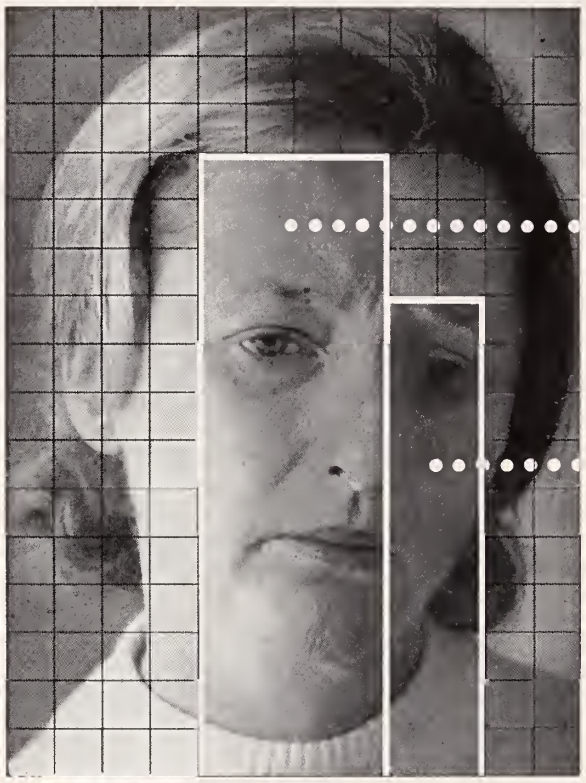
Additional information available to the profession on request.

*Present as 345.9 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. fenoprofen.

600091

This Month . . . Proceedings of the House of Delegates, Constitution and By-Laws

Both often



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

TO COMPLETE YOUR HEALTH INSURANCE PICTURE, MSMA OFFERS ITS NEW COMPLETE HEALTH INSURANCE PACKAGE:

NEW MAJOR MEDICAL PLAN

Covers 80% of your eligible expenses after you satisfy your deductible amount. Choice of deductibles available. Pays expenses in and out of the hospital!

NEW HOSPITAL MONEY PLAN®

Pays a daily benefit for each day you spend in the hospital because of an accident or illness. Acceptance is GUARANTEED! Pays the benefits directly to *you*!

NEW EXCESS MAJOR MEDICAL PLAN

Picks up where basic insurance programs leave off. Pays 100% of eligible expenses in or out of the hospital—up to $250,000 maximum. And, premiums are LOW! Acceptance is GUARANTEED!

A complete health insurance picture is probably one of the most important items you can provide for your family's financial well-being. To help you combat the rising cost of hospital and medical care, MSMA has entirely revamped its health insurance program to give you the most complete and comprehensive program available . . . and at a low price all can appreciate. Find out more. Mail the coupon below for more information:

THE MSMA INSURANCE PROGRAMS ARE UNDERWRITTEN BY:

CONTINENTAL CASUALTY Co.
ASSOCIATION GROUP DIVISION
Chicago, IL 60685

a division of CNA/insurance

Please send me more details on the NEW MSMA insurance programs:

☐ **MSMA MAJOR MEDICAL PLAN** ☐ **MSMA HOSPITAL MONEY PLAN** ☐ **MSMA EXCESS MAJOR MEDICAL PLAN**

NAME_____

ADDRESS_____

CITY_____

STATE_____ ZIP CODE_____

MAIL TO: Thomas Yates & Co., MSMA Insurance Administrators
P.O. Box 1054, Jackson, Mississippi 39205

Volume XVII
Number 8
August 1976



JOURNAL of the Mississippi
STATE MEDICAL ASSOCIATION

• EDITOR
W. Moncure Dabney, M.D.
• ASSOCIATE EDITORS
George H. Martin, M.D.
Myron W. Lockey, M.D.
• MANAGING EDITOR
Nola Gibson
• PUBLICATIONS COMMITTEE
Lawrence W. Long, M.D.
Chairman
Robert R. McGee, M.D.
T. A. Baines, M.D.
and the editors
• THE ASSOCIATION
Lyne S. Gamble, M.D.
President
James O. Gilmore, M.D.
President-Elect
J. Elmer Nix, M.D.
Secretary-Treasurer
C. D. Taylor, Jr., M.D.
Speaker
R. Faser Triplett, M.D.
Vice Speaker
Charles L. Mathews
Executive Secretary
H. Cody Harrell
Assistant Executive Secretary
William F. Roberts
Legal Counsel

The Journal of the Mississippi State Medical Association is owned and published monthly by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, $15.00 per annum; $2 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

CONTENTS

SPECIAL ARTICLES

Proceedings of the House of Delegates **211** 108th Annual Session of MSMA

Constitution and By-Laws **243** Annual Publication

EDITORIAL

Position Paper on Mammographic Examinations **253** American College of Radiology

THIS MONTH

The President Speaking **252** "The AMA Meeting in Dallas"

Medical Organization **257** MSMA Council on Scientific Assembly Begins Planning 1977 Annual Session

Because of marked increases in the cost of printing the Journal MSMA, your publication committee has again elected to limit this edition to the transactions of the annual session, and to changes in the constitution and by-laws, together with news and features. This is a common practice in other state Journals.—WMD

Copyright 1976, Mississippi State Medical Association

A Major Factor In Your Practice

With today's inflation, how much does it cost to keep abreast of the advances in medicine?

Would you believe only $30.00 a year?

That's the full cost of an annual membership in Southern Medical Association.

Unbelievable. Incredible. But true.

Where in today's inflationary world can you duplicate these major factors for such a nominal cost?

★ Annual Scientific Assembly: (No registration fee for members), termed the outstanding medical meeting of the year, with distinguished lecturers and participants in every medical discipline, including more than 20 postgraduate courses, granted full approval for Category I credit by the AMA's Council on Medical Education.

★ **Southern Medical Journal:** Every member receives the monthly **Journal**, recognized as the medical publication with the most thorough scientific coverage of any in the country. (**Southern Medical Journal** publishes more original clinical material than any other medical journal in the world!) Plus the bimonthly **Southern Medicine**, featuring general informative articles of interest to physicians.

★ Group Insurance Program: Includes hospital and major medical, up tc $100,000 life coverage, plus retirement (this insurance program itself is worth far more than the nominal annual dues).

Southern Medical's program, providing these great benefits, will help you become a better physician. Write today for an application and join 22,000 dedicated members who already realize the importance of membership in this vital organization.

STILL ONLY $30.00 A YEAR

Southern Medical Association

2601 Highland Avenue • Birmingham, Alabama 35205 • 205/324-4608

ANNUAL SCIENTIFIC ASSEMBLY

NEW ORLEANS—NOV. 7—10, 1976

State Health Planning Council Named

Governor Cliff Finch has announced appointment of Mississippi's State Health Coordinating Council under requirements of Public Law 93-641.

The 30 member council will direct and advise the State Health Planning and Development Agency which Governor Finch recently designated from his Office of Comprehensive Health Planning.

The council's membership contained few surprises. Mr. Fred St. Clair, the governor's recent appointee as Commissioner of Public Welfare and former President of the Mississippi Health Systems Agency, Inc. was elected chairman. Dr. Aaron Henry, who is perhaps best known for his work with the Mississippi Democratic "Loyalists" Party now combined with the "Regulars" was named to the council as well as Senators Theodore Smith and Nap Cassibry.

Senator Smith's acceptance of the appointment to the council was surprising in view of his annual speeches to his legislative colleagues about the evils of their serving on various "executive branch commissions, boards and councils." Senator Smith is not only on the new "executive branch" council but also serves as the chairman of the council's committee to review projects requesting federal health funds.

Members of the council are: Mr. Tom Alexander, Jackson; Mr. Douglas Anderson, Jackson; Mr. W. K. Anderson, Jackson; Mr. Larelle Ashley, Jackson; Mr. H. W. Bailey, Crowder; Dr. Jim Barnett, Brookhaven; Mrs. Troy Bostick, Starkville; Dr. Albert B. Britton, Jr., Jackson; Mr. Conner Cain, Jackson; Senator Nap Cassibry, Gulfport; Dr. Howard Clark, Morton; Dr. Douglas Conner, Starkville; Mr. Johnny Crane, Fulton; Mr. F. W. Ergle, Jr., Charleston; Dr. Mable Garner, Fayette; Mrs. Myrna Green, Waynesboro; Dr. Aaron Henry, Clarksdale; Ms. Patsy Hester, Long Beach; Mr. J. C. Hillman, Richton; Mr. Lester Howell, Greenwood; Mr. Calvin J. Isaac, Philadelphia; Mrs. Pauline Hendricks, Greenville; Dr. Larry M. Mitchell, Pascagoula; Mr. Larry Pratt, Batesville; Senator Theodore Smith, Corinth and Mr. Fred St. Clair, Jackson.

Is there a tablet containing *only* an expectorant and *only* Glyceryl Guaiacolate? YES!

1. Patient acceptable tablet dose.
2. Single entity expectorant.
3. Measured tablet dose.
4. Sugar-free tablet.

An identifiable white, scored tablet which significantly stimulates the secretion of respiratory tract fluid.

HYTUSS TABS

(GLYCERYL GUAIACOLATE 100mg.)





Composition: Each sugar-free compressed tablet contains glyceryl guaiacolate 100mg. **Action and Use:** This preparation utilizes the effective expectorant action of glyceryl guaiacolate which significantly stimulates the secretion of respiratory tract fluid. The increased flow of less viscid fluid favors expectoration and has a demulcent effect on the tracheobronchial mucosa. The primary usefulness of Hytuss Tabs is to promote the change from a dry, unproductive cough to a productive cough. Hytuss is therefore useful in treating coughs due to the common cold, bronchitis, laryngitis, tracheitis, pharyngitis, influenza and the measles. The expectorant action of Hytuss may also provide symptomatic relief in some chronic respiratory disorders when the patient experiences spasms of dry nonproductive coughing. **Precautions:** Extremely large amounts may cause nausea and vomiting. **Administration and Dosage:** *Adults*—1 tablet four times daily. *Children*—6 to 12 years of age; ½ tablet 3 or 4 times daily. HOW SUPPLIED: White, scored, sugar-free, tablet in bottles of 100 - 1,000 - 5,000. **Product Identification Mark:** Hy. **Literature Available:** On request.

Available through all drug wholesalers.

Hyrex

HYREX COMPANY

832 South Cooper
Memphis, Tenn. 38104

consider the effect on coexisting glaucoma when you prescribe a vasodilator*



a vasodilator that has not been reported to raise intraocular pressure

VASODILAN®
(ISOXSUPRINE HCl)

TABLETS, 20 mg.

the compatible vasodilator

Mead Johnson LABORATORIES

© 1970 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL-54118

*__Indications:__ Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

NEWSLETTER

August 1976

Dear Doctor:

The role of the federal government in the country's health system presents "a very real conflict of interest," according to M. D. Bromberg, Federation of American Hospitals president in an address to the Texas Hospital Association. He said the government's conflict of interest arises from its position as "both the purchaser of health care services while also being the regulator of the price of that care...the net result being that the quality of health care suffers."

> "Those of us involved in the health field know that price controls on a single industry, without controls over such costs as labor or supplies force a reduction in the quality of patient care. But to the general public, proposals for regulating 'those outrageously high' hospital charges sound like an idea worth considering," said Bromberg.

Legislation amending the Public Health Service Act has changed the name of the National Heart and Lung Institute to the National Heart, Lung, and Blood Institute. A major provision of the legislation is an increase in blood-related activities in the institute and National Heart, Blood Vessel, Lung and Blood Program, including research on hemorrhagic diseases, clotting disorders and sickle cell.

The fourth edition of the AMA's Current Procedural Terminology is scheduled for publication by the end of the year, according to the AMA's In Brief Newsletter. Companion computer tapes for the new edition will be available for use in billing and insurance reporting. The 3rd edition of CPT was published in 1973 so the 4th edition will contain many new procedures.

The AMA's Physician Placement Service is operating under a new computerized matching system. Now that the system is fully automated, registrations are expected to increase 75 to 100 per cent during the next year, says the AMA. The service is also expanding its activities to include solicitation of employment opportunities. For information write Div. of Physicians Placement, AMA, 535 N. Dearborn, Chicago.

The association's "chiropractic suit" went to trial in Hinds Chancery Court on June 15. The case, originally set to last two days, took some five days for MSMA to present its case. Nine hours of the five days was taken by MSMA and the rest by the defense, mostly on cross examination. The case has been continued to the next term of court during September 7-10 and 13, if necessary.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

Doctors Are Dropping Malpractice Insurance

An American Medical Association physician poll indicates that one out of three doctors is considering "going bare"—practicing without any malpractice insurance.

And one out of eight respondents in the poll—13 per cent—said he or she was currently without malpractice insurance.

The doctors either have dropped or are considering dropping insurance because of the escalating cost of premiums—in some states now upwards of $30,000 annually for physicians in high risk specialties.

Half of the surgeons (49 per cent), 44 per cent of the obstetrician-gynecologists, and surprisingly 41 per cent of psychiatrists said they are considering dropping malpractice insurance. Pediatricians (13 per cent) were the least inclined to favor the idea.

MAFP Is Cosponsoring M.D. Mental Health Workshop

A workship on mental health with the theme "Learning to Cope With the Pressures on the Physician and His Family" will be sponsored Sept. 10-12 at the Grand Hotel, Point Clear, AL, by the Mississippi and Alabama chapters of the American Academy of Family Physicians.

The week-end training session is for couples and will examine the responsibility of the physician to himself, his family and his patients. It is an experience-based learning program using techniques of experiential learning and taking a practical look at how to deal with those stressful moments in life. The workshop will also provide written and bibliographic materials.

Faculty will be Dr. Howard M. Kern, former associate professor of psychiatry at Johns Hopkins; Dr. Herbert Klemme, a psychiatrist who was a family physician for 12 years; and Sherman Kingsbury, Ph.D., a social psychologist on the teaching staff of Case Western Reserve University.

Mississippi physicians on the program committee are Drs. John G. Atwood of Meridian, co-chairman, and Ray H. Stewart of Gulfport.

The program has been approved for 13 prescribed hours by the American Academy of Family Physicians.

For further information and registration forms, write Joyce Golden, Executive Director, Alabama Academy of Family Physicians, 19 S. Jackson St., Montgomery, AL 36104.

for the inflamed phase of hemorrhoidal flare-up

ANUSOL-HC® SUPPOSITORIES
Rectal Suppositories with Hydrocortisone Acetate

ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate

CAUTION: Federal law prohibits dispensing Anusol-HC Suppositories and Anusol-HC Cream without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian Balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: bismuth subiodide, calcium phosphate, and coloring in a bland hydrogenated oil-cocoa butter base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg. benzyl benzoate, 12.0 mg; Peruvian Balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, bismuth subiodide, propylparaben, methylparaben, polysorbate 60, sorbitan monostearate in a water-miscible base of mineral oil and glyceryl monostearate. Non-staining.

Indications: Anusol-HC is adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis and fissures, incomplete fistulas, and relief of local pain following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. When acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: History of sensitivity to any component. Topical corticosteroids should not be employed in tuberculous, fungal and most viral lesions of the skin (including herpes, vaccinia and varicella).

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy they should not be used unnecessarily on extended areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment. When there is bacterial skin infection, topical corticosteroids should be used only with appropriate concomitant antimicrobial therapy. Prolonged or excessive use of corticosteroids might produce systemic effects.

Dosage and Administration: Anusol-HC Suppositories: Remove foil wrapper and insert into the anus. One suppository in the morning and one at bedtime, for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol.

Anusol-HC Cream: Adults—Remove tube cap and attach the plastic applicator. After gentle bathing and drying of the area, apply to the exterior surface and gently rub in. For internal use, insert the applicator by applying gentle, continuous pressure. Then squeeze tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol.

Supplied: Anusol-HC Suppositories—boxes of 12 (N 0047-0089-12) suppositories in silver foil strips with (WC) printed in black.

Anusol-HC Cream—one-ounce tube (N 0047-0090-01) with plastic applicator; detachable label.

Full information is available on request.

Warner/Chilcott
Division,
Warner-Lambert Company,
Morris Plains,
New Jersey 07950

AN-GP-51-4C

THE PROFESSIONAL SOURCE OF

COMFORT

FOR INTERNAL & EXTERNAL ANORECTAL CONDITIONS

Anusol-HC®

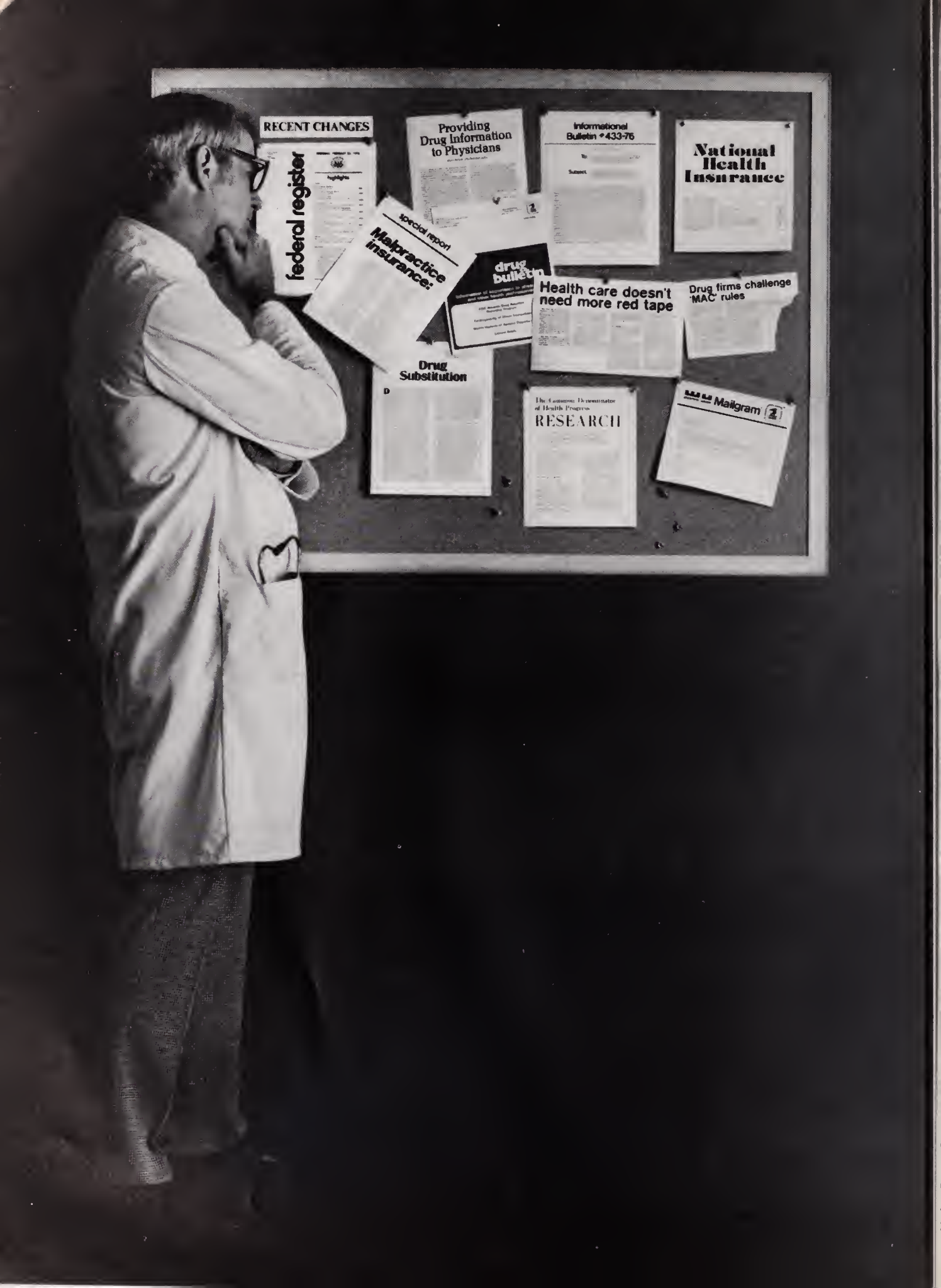
suppositories and cream
with hydrocortisone acetate. Rx only

pain and burning respond in minutes

- without belladonna alkaloids
- without CNS stimulants



Artist's interpretation in bas-relief of external hemorrhoids, postoperative anorectal wounds and anal dermatitis.


RECENT CHANGES
federal register
Providing Drug Information to Physicians
Informational Bulletin #433-76
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Famous Fighters



NEOSPORIN® Ointment
(polymyxin B-bacitracin-neomycin)
is a famous fighter, too.

Provides overlapping, broad-spectrum antibacterial action to help combat infection caused by common susceptible pathogens (including staph and strep).

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units, zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

DATELINE

Patient Grievance System Required

Denver, CO - A 1976 Colorado statute requires all hospitals and related facilities with more than 50 beds to submit for state approval a plan for the institution of a patient grievance system within the facility. The plan must include provision for a patient representative to serve as a liaison between patients and the facility. Approval of the plan is made a condition for a certification of compliance, or for issuance or renewal of a license.

SESAP Correlated with ACS Recertification

Chicago, IL - American College of Surgeons and American Board of Surgery have agreed to correlate the college's Surgical Education and Self-Assessment Program (SESAP) with the board's recertification process. First voluntary recertification exam is to be offered in fall of 1980. ABS will inform candidates for recertification they should be familiar with SESAP. Agreement in essence emphasizes the part of ACS is education and the board, determination of knowledge and competence.

Alabama Monitors Pacemaker Recipients

Birmingham, AL - People with hearts regulated by pacemakers installed by cardiac surgeons at the University of Alabama Medical Center in Birmingham are served by the center's transtelephone pacemaker monitoring system. It allows a patient to "phone in" an electrocardiogram reading and other pacemaker data by attaching two bracelets to his forearms and placing the phone in the transmitting unit. Patients can use the service from any location in the world.

Pop Tops Can Be Dangerous

Chicago, IL - Seven cases of children swallowing those metal strips from "pop top" beverage cans were reported in the June 14 issue of JAMA. Dr. John D. Burrington of the Pritzker School of Medicine reported that in six of the seven, the pop top strip was removed successfully. The seventh child died when the tab cut through the esophagus into an artery. In none of the seven cases was the parent aware that the child had picked up a strip of metal and swallowed it.

Inter-City Youth Learn Peer Prevention Skills

Washington, D.C. - Inter-city junior and senior high school youths are trained in counseling skills and then sent back to their peer groups to conduct workshops and seminars on alcohol issues in an alcohol abuse prevention project here. The Alcohol Abuse Education/Prevention Program at Federal City College uses the "peer education" model to encourage young people in the development of responsible attitudes about alcohol use.

FAMILY PRACTICE PHYSICIANS

Openings for Family Practice Physicians in group practice. Excellent starting salary. If performance and qualifications are fulfilled, a sharing partnership is possible. Physician owned hospital adjoining. This is an opportunity to practice family medicine as training in this specialty is intended. Only U. S. medical school graduates need apply. Third year resident applications are encouraged.

Contact

John M. Canakaris, M.D.,
Bunnell General Hospital
Bunnell, Florida 32010
Telephone (904) 437-3354

it's the real thing

Enjoy Coca-Cola Trade-mark ®

70-37

Mississippi Council of Coca-Cola Bottlers

Medical Exploring Groups Established in State

Exploring, the young adult division of the Boy Scouts of America, now has an organization, National Association of Medical Explorers (NAME), that is aimed at bridging the gap between interest and experience in medicine in relation to choosing a health career.

Currently, medical Explorers number more than 50,000 youth between the ages of 15 and 21, registered in 1,900 posts. Making up almost 12 per cent of Exploring's total membership, medical and health careers is the largest single career special interest in the Exploring program. The Mayo Clinic has sponsored a medical Explorer post since 1962.

Medical Explorer post groups have been organized in Mississippi in cooperation with Montfort Jones Hospital in Kosciusko, Leake County Memorial Hospital in Carthage, Holmes County Community Hospital in Lexington, and District Two Hospital in Durant. The purpose of these groups is to allow Explorers to become acquainted with the various health careers. Activities include orientation to the total hospital environment, medical ethics, planned clinical experiences rotating through the various medical service areas such as nursing, radiology, pharmacy, dietary, laboratory, etc.

Post advisors are: Malcolm McDonald of Carthage (x-ray technician); John Washburn of Kosciusko (respiratory therapist); Dr. Arthur Derrick of Durant (family physician); Dr. Charles Heath of Lexington (DVM); and Connie Juguziak of Lexington (registered nurse).

Exploring is for young adults, male and female, between the ages 15 and 21 and in the young adult division of the Boy Scouts of America. Each medical post member is associated with the NAME, which is under a three-year grant in aid from the American Medical Association for a program of expansion and enrichment of medical and health career Exploring.

Other cooperating professional organizations are: American Hospital Association, American Dental Association, American Nurses Association, American College of Hospital Administrators, National Association of Retail Druggists, American Podiatry Association, American Veterinary Medical Association, National Health Council, Department of Defense (U. S. Air Force, U. S. Army Health Services Command, U. S. Navy Bureau of Medicine and Surgery), Association of Schools of Allied Health

Careers, and American Optometric Association.

Through the National Association of Medical Explorers, the resources of organizations like the above can be made available in support of local post programs.

NAME provides the major communications link between Explorers with a common interest in health careers. A quarterly publication, the *Medical Exploring Newsletter* is distributed to the Advisor of each medical post with copies for his post officers.

The association actively promotes several medical Explorer conferences in various parts of the country and is involved with national conventions of a number of professional health care organizations.

A manual, *Medical Exploring* is available as a basic source book for the program while *Post Programming Manual,* written by the Explorers themselves gives helpful hints on program development.

Direct service to local BSA councils and posts is available through NAME national, regional, and area officers.

Further information can be obtained from Director Medical Exploring, Exploring Division, BSA, North Brunswick, NJ 09802, phone: (201) 249-6000, extension 727.

PRINTING — OFFICE SUPPLIES

EQUIPMENT — FURNITURE



Premier Printing Company

2485 West Capitol Jackson, Mississippi

Phone 352-4091

helping you change things for the better

Canton Exchange Bank

A FULL SERVICE BANK

"Your Account Handled in Strict Confidence"

Each depositor insured to $40,000

Branch Offices

Canton East Branch
Bank Of Madison
Bank Of Ridgeland

FDIC

Federal Deposit Insurance Corporation

"Our 95th Year Of Continuous Service"

Volunteers Are Needed for Hypertension Study

Volunteers are needed for a University of Mississippi Medical Center study of the effect of potassium loading on dietary manipulations in blood pressure.

UMC professor of medicine Dr. Herbert G. Langford said hypertension patients without extensive organ damage are needed for the study.

Volunteers, who should not be receiving hypertension treatment at the time of the study, will be hospitalized at no expense for three-and-a-half weeks. Patients will also receive $10 a day for lost work time and inconvenience.

Dr. Langford prefers patients aged 30 to 65 for the continuing study supported by the National Institutes of Health-funded UMC Clinical Research Center and a Morton Salt grant to the Medical Center.

Physicians who have interested patients should contact Mrs. Cecile Brocato, Chief Nurse, Clinical Research Center, University Medical Center, 2500 North State Street, Jackson, MS 39216.

Lung Association Awards Two New Research Grants

The Mississippi Lung Association has awarded two new research grants totaling $9,100 to University of Mississippi Medical Center Personnel.

Dr. H. M. Mehendale, UMC assistant professor of pharmacology-toxicology, and pulmonary medicine fellow Dr. M. D. Hardy, Jr., are grant recipients.

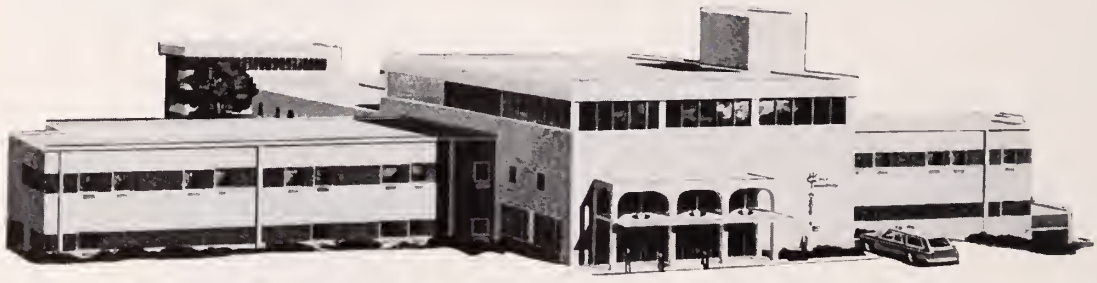
Lung Association Board of Directors President J. Sneed McInvale of Laurel and UMC Vice Chancellor Dr. Norman C. Nelson jointly announced the new research awards, part of the state lung association's effort to improve care for Mississippians with respiratory illnesses.

Dr. Mehendale will study "epoxidase activity in the developing rabbit lung" and Dr. Hardy "high-dose intravenous methylprednisolone in status asthmaticus."

The lung association also supports a Christmas Seal professor of respiratory disease and the pulmonary medicine fellowship program at the Medical Center.

Hill Crest
HOSPITAL
Hill Crest Foundation, Inc.

A non-governmental psychiatric hospital. Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved.
Phone: 205-836-7201



A short-term, intensive treatment center for psychiatric disorders, alcoholism, and drug abuse.

Member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Birmingham Regional Hospital Council.

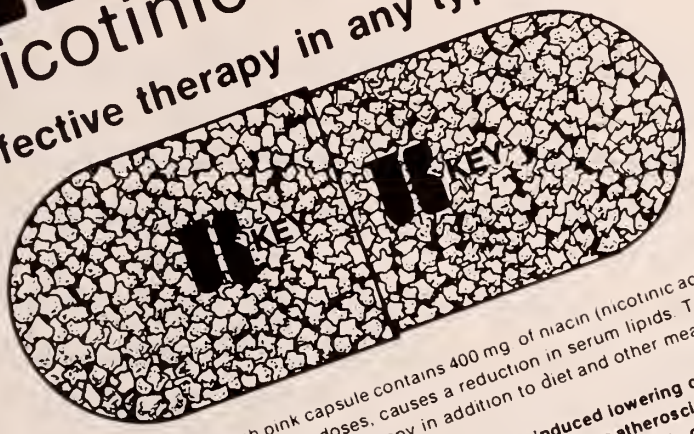
6869 Fifth Avenue South
Birmingham, Alabama 35212

The Original
Slow Release
Form of Nicotinic Acid

nico-Span®

(nicotinic acid) 400 mg. capsules

Effective therapy in any type of drug responsive hyperlipidemia.



DESCRIPTION: Each pink capsule contains 400 mg. of niacin (nicotinic acid) in a special pelletized formulation for prolonged release

ACTIONS: Niacin, in large doses, causes a reduction in serum lipids. The exact mechanism of action is unknown

INDICATIONS: As adjunctive therapy in addition to diet and other measures in the treatment of hypercholesterolemia and hyperbetalipoproteinemia.

Notice: It has not been established whether drug-induced lowering of serum cholesterol or other lipid levels has a detrimental, a beneficial or no effect on the morbidity due to atherosclerosis or coronary heart disease. Several years will be required before current investigations can yield an answer to this question.

CONTRAINDICATIONS: Niacin is contraindicated in patients with hepatic dysfunction or in patients with active acute peptic ulcer.

WARNINGS: The use during pregnancy and lactation or in women of childbearing age requires careful weighing of potential benefits versus possible hazards to the mother and child. There are insufficient studies done for usage in children.

PRECAUTIONS: Patients with diabetes, gall bladder disease, past history of jaundice, liver disease, or peptic ulcer should be observed closely. At initial stage of therapy, liver function and blood glucose should be monitored at frequent intervals. Adjustment of diet and/or hypoglycemic therapy may be necessary. Patients undergoing antihypertensive therapy may experience an added vasodilating effect with resulting postural hypotension. Use with caution in patients predisposed to gout

ADVERSE REACTIONS: Severe flushing, decreased glucose tolerance, activation of peptic ulcer. abnormal liver function tests, jaundice, gastrointestinal disorders, dry skin, pruritus, hyperuricemia, toxic amblyopia, hypotension, transient headache

DOSAGE AND ADMINISTRATION: The dose and frequency for the administration of NICO-SPAN should be adjusted to the response of the patient. Slow build-up of dosage in gradual increments is recommended to observe efficacy and/or adverse effects. One or two capsules three times a day is the usual dosage. The maximum daily dosage is 6 grams.

Please arrange to provide starter samples and/or complimentary "Starter" prescription booklets for:
nico-Span® (nicotinic acid, 400 mg.)

Samples ☐ "Starter" Rx's ☐

Dr. _____ Specialty _____

Street _____

City _____ State _____ Zip _____

Mail to: Key Pharmaceuticals, Inc. 50 N.W. 176th Street, Miami, Florida 33169

KEY PHARMACEUTICALS, INC.
Miami, Florida 33169 (U.S.A.)



Presenting new deductible contracts for non-group members —

An option for subscribers to control their health care costs.



Blue Cross and Blue Shield of Mississippi is as concerned about rising health care costs as are its subscribers. The Plan has designed a new method of providing optional rates to non-group members: new deductible contracts.

The present non-group Basic contract has a $25 deductible clause on each hospital admission or readmission. Now, non-group members may choose to increase that deductible amount to $100, $200, or $300. In this manner, a choice of reduced rate schedules is available.

The new deductible contracts are another effort by Blue Cross and Blue Shield to relieve the pressure on health care costs. Our goal remains to offer our members the best possible coverage at the lowest possible price.

It's a continuing struggle. But, working together, we can help contain the rising costs of health care.





Blue Cross®
Blue Shield®
of Mississippi

P. O. Box 1043/530 E. Woodrow Wilson Ave./Jackson, Mississippi 39205
Tel. 982-0010

® Registered Marks Blue Cross Association
® Registered Service Marks of the National Association of Blue Shield Plans

Proceedings of the House of Delegates

108th Annual Session
May 3-6, 1976
Jackson, Mississippi

THE 73RD ANNUAL SESSION of the House of Delegates was convened during the 108th Annual Session of the Mississippi State Medical Association, in pursuance of lawful notice given, on May 3, 1976, in the Delta Hall I, Holiday Inn Downtown, Jackson, Mississippi, at 9:00 o'clock in the morning by Dr. Jack A. Atkinson of Brookhaven, president. The invocation was spoken by Dr. Donald G. Manuel of Brookhaven.

After extending greetings, Dr. Atkinson presented the vice speaker, Dr. R. Faser Triplett of Jackson, and the speaker, Dr. C. D. Taylor, Jr., of Pass Christian, who assumed the chair. Dr. James P. Spell of Jackson, chairman of the Reference Committee on Credentials, reported the presence of a quorum of 110 registered and seated delegates in accordance with Section 3, Chapter V, By-Laws of the association.

ANNOUNCEMENT OF THE REFERENCE COMMITTEES

Report of Officers, Councils and Board of Trustees
- Everett Crawford, Tylertown, Chairman
- Virginia Tolbert, Ruleville
- Robert F. Carter, Jr., Biloxi
- George Ball, Jackson
- William J. Burnett, Oxford

Constitution and By-Laws
- W. Lamar Weems, Jackson, Chairman
- Mary J. Ward, Corinth
- Louis C. Lehmann, Natchez

Rules and Order of Business
- Stanley A. Hill, Corinth, Chairman
- J. Edward Hill, Hollandale
- Joseph C. Hillman, Brookhaven

Credentials
- James P. Spell, Jackson, Chairman
- Tom H. Mitchell, Jackson
- Howard D. Clark, Morton

APPOINTMENT OF TELLERS AND SERGEANTS-AT-ARMS

The three vice presidents were designated as tellers. They are: J. Edward Hill of Hollandale, W. Briggs Hopson, Jr., of Vicksburg, and J. P. Culpepper, Jr., of Hattiesburg. Dr. Culpepper was absent so the chair asked Dr. Larry Day of Hattiesburg to serve in his place.

REPORT OF THE REFERENCE COMMITTEE ON RULES AND ORDER OF BUSINESS

To assist the speaker and vice speaker in the orderly conduct of the proceedings of this House of Delegates, your Reference Committee on Rules and Order of Business makes the following recommendations:

Conduct of Business. Under the by-laws, the business of the House must be conducted according to *Sturgis Standard Code of Parliamentary Procedure,* and the speaker and vice speaker should prescribe the order of business as set out in the by-laws. To insure proper recording of the transactions, all delegates recognized should identify themselves. Except for distinguished visitors and those having official capacity in the association, unanimous consent should be obtained for extending the privilege of the floor to nonmembers of the House of Delegates. The report of the Reference Committee on Credentials should constitute the formal and official roll call of the House.

Reference Committees. The purpose of reference committees is for affording all members of the association an opportunity to discuss their views on matters under consideration by the House of Delegates.

Reports. All reports and resolutions presented should be referred to the appropriate reference committee by the chair immediately after their presentation, the only exception being those which are of such a nature as to require no further consideration and are, therefore, ready for decision by vote of this House. Reports published in the *Handbook of the House of Delegates* are considered to have been formally presented and should be referred to appropriate reference committees by the chair. Debate should be reserved on all such presentations until such time as the reference committees conduct formal hearings and when they report to the House.

Resolutions. To avoid burdensome tasks upon the reference committees and to insure that all members have adequate opportunity to discuss their views, the House should permit no introduction of resolutions after the present meeting except for (1) matters of an emergency nature, the validity of such emergency to be determined by majority vote, (2) matters relating to a scientific section of scientific work, and (3) proposed amendments to the Constitution and By-Laws which would then lie on the table for one year.

The report of the reference committee was adopted.

ADOPTION OF TRANSACTIONS

On motion by Dr. Stanley A. Hill of Corinth, seconded by Dr. Calvin Hull of Jackson, the Transactions of the 72nd Annual Session of the House of Delegates, 107th Annual Session of the association, May 5-8, 1975, published in Volume XVI, Number 8, JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, August 1975; and the Transactions of the Special Session of the House of Delegates, October 23, 1975, published in Volume XVII, Number 4, JOURNAL MSMA, April 1976, were adopted.

REMARKS OF THE SPEAKER

Dr. C. D. Taylor, Jr.: The speaker and vice speaker will conduct the House of Delegates in such a manner as to allow each and every one who is qualified to enter into the business of this House of Delegates. We remind the members that the reference committees are the real forums for discussion and the issues should be debated there, and brought to the whole body for action. Business will be conducted according to Sturgis Rules of Order as prescribed by our By-Laws.

The speaker, in reflecting over the past several years of action of the House, would like to make a suggestion. Instead of providing a handbook for the delegates that is incomplete and supplemented by the introduction of interim reports at the first meeting of the House, we provide a complete delegates' folder to each delegate two weeks prior to the annual session. This would allow time for perusal of the material at home prior to the meeting of the House. On the Sunday prior to opening day the association sponsors a reception for the delegates and officers in the early evening. If we convened the House of Delegates at 3:00 p.m. on Sunday afternoon for the President's address, the introduction of visiting dignitaries, the address of the president of the AMA and the one or two formal opening resolutions and pieces of business, then we could hold such reference committee meetings on Monday as necessary to properly discuss the business of the association without overlapping times. In 1975 several actions were taken that showed the fact that some of our members with expertise on several subjects were unable to be present at two committees simultaneously. Much of our business is involved in the socioeconomics of medicine and it would behoove us to do our planning well, because there are many waiting handily in the wings of the arena to direct our destinies.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS, COUNCILS, AND BOARD OF TRUSTEES

Your reference committee considered the report from our speaker and vice speaker. We commend them for the fair and impartial manner in which they preside over this House of Delegates. In the report our speaker has specifically recommended that (1) the House of Delegates convene on Sunday afternoon at the next annual session; (2) that all reports of the Board and councils be sent to delegates two weeks prior to the annual session; and (3) that except for emergency business, only the address of our president and other distinguished guests be presented to the House. Within this recommended format, the reception for the House of Delegates would be conducted following adjournment on Sunday and Monday would be open for meetings of reference committees and the Mississippi Foundation for Medical Care.

Your reference committee heard support for the speaker's recommendation and we concur with the recommendation. However, it is also our recommendation that the closing session of the House of Delegates be held on Wednesday afternoon instead of Thursday morning.

After discussion of the recommendation, Dr. Sidney Graves of Natchez moved that the recommendation of the reference committee be *tabled for further study*. The motion was seconded by Dr. G. Swink Hicks of Natchez and adopted.

The report of the reference committee was referred for further study.

PRESENTATION OF DISTINGUISHED GUESTS

The speaker presented the following distinguished guests:

Mrs. Eleanor Atkinson, Brookhaven, Mississippi

Dr. and Mrs. Robert H. Atkinson, Hot Springs, Arkansas

Ms. Carla Neuschel, AMA Representative, Chicago, Illinois

Dr. Max Parrott, AMA president, Portland, Oregon

Mr. Jim Reynolds, Washington Editor, Medical Economics

Ms. Sallye Ball, president, Mississippi Nurses Association

Mr. Sam Cameron, vice president, Mississippi Hospital Association

Mr. George Butler, president, Blue Cross-Blue Shield of Mississippi

Mr. Chan Moseley, vice president, Blue Cross-Blue Shield of Mississippi

Mr. Aaron Johnston, vice president, Blue Cross-Blue Shield of Mississippi

Mr. Will Lowery, assistant director, Mississippi Medicaid Commission

Members of the Press

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

Dr. C. D. Taylor, Jr.: Two amendments to the MSMA Constitution and By-Laws were presented at the 107th Annual Session and are on the table for action by the House of Delegates today. One dealing with the Council on Medical Education changes the composition of the council from three members customarily elected from the north, central and south areas of the state to one member elected from each of the scientific sections. This amendment, if adopted, will be implemented during the scientific section meetings on Tuesday and Wednesday. The amendment reads as follows:

MSMA By-Laws—Chapter IX

"Section 9. Council on Medical Education. The Council on Medical Education shall consist of one member elected from each of the scientific sections for terms of three years each which are so arranged so that no more than three members are elected annually. To this council shall be assigned the responsibilities of encouraging undergraduate and postgraduate study of medicine, licensure, and facilities for medical education in the state. This council shall be responsible to the Board of Trustees."

The other amendment considered at the 107th Annual Session was an amendment to both the MSMA By-Laws and Constitution and as such has laid on the table for final action at the 108th Annual Session. The amendment, if adopted, will realign and reduce from nine to eight the association districts as specified in Chapter VIII, Section 8, MSMA By-Laws. This is one of several redistricting plans that have been before the House of Delegates since the 106th Annual Session. The plans have been presented in response to an expression by the House of Delegates at the 105th Annual Session in 1973 that there should be a more equal ratio of members between districts. Previous redistricting plans before the House of Delegates would have realigned several component medical societies if adopted. The redistricting plan before the House this year does not change any component society boundary. The redistricting plan does reduce the number of association districts from nine to eight and combines association districts 1, 2, 3, 4, and 6 into three new districts.

The proposed amendment amends Section 8, Chapter VII, MSMA By-Laws to read as follows (changes are in italics):

MSMA By-Laws—Chapter VII

"Section 8. Association Districts. The state of Mississippi shall be subdivided into association districts by counties, provided that all counties in a component society shall be in one association district. These districts are defined as follows:

District 1: *Attala,* Bolivar, *Carroll, Choctaw,* Coahoma, *Grenada, Holmes,* Humphreys, Leflore, *Montgomery,* Quitman, Sunflower, Tallahatchie, Tunica, Washington, *Webster.*

District 2: *Alcorn,* Benton, *Calhoun, Chickasaw,* DeSoto, *Itawamba,* Lafayette, *Lee,* Marshall, *Monroe,* Panola, *Pontotoc, Prentiss,* Tate, Tippah, *Tishomingo,* Union, Yalobusha.

District 3: *Clarke,* Clay, *Kemper, Lauderdale,* Lowndes, *Neshoba, Newton,* Noxubee, Oktibbeha, *Winston.*

Districts 4 and 5: Hinds, Madison, Leake, Rankin, Scott, Simpson, Yazoo.

District 6: *Adams, Amite, Claiborne, Copiah, Franklin, Issaquena, Jefferson, Lawrence, Lincoln, Pike, Sharkey, Walthall, Warren, Wilkinson.*

District 7: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Pearl River, Perry, Smith, Wayne.

District 8: *Hancock, Harrison, Jackson, Stone.*

The following other sections of the MSMA Constitution and By-Laws would be changed by the proposed amendment to indicate the number of new

association districts.

MSMA Constitution and By-Laws
Article IX
Chapter VI
Chapter VIII
Chapter IX—Sections 2, 4 and 6
Chapter X—Section 3

The speaker called for discussion on the amendment before the House to Chapter IX, Section 9, MSMA By-Laws. Dr. Charles N. Floyd of Gulfport moved that the proposed amendment be amended to provide that "The Council on Medical Education shall consist of one member elected from each association district for terms of three years each which are so arranged so that no more than three members are elected annually. . . ." The amendment to the amendment was seconded by Dr. Carl G. Evers of Jackson.

Dr. Floyd discussed the amendment pointing out that the association's scientific programming and accreditation should be conducted by two distinct bodies which would not be the case if the scientific sections appointed the members of the Council on Medical Education as proposed by the original amendment. He further noted that the original amendment would not assure geographic representation on the Council on Medical Education which was most important to the council's activities at this time. There being no further discussion, the speaker called for a vote on the amendment to the amendment by Dr. Floyd and the amendment was adopted. The speaker then called for a vote on the amendment as amended and the amendment was adopted.

The speaker next called for discussion on the amendment before the House to Chapter VII, Section 8, MSMA By-Laws. There being no discussion, the speaker noted that the amendment amended the MSMA Constitution and would thus require a two-thirds vote of those present and voting.

A standing vote was then called for and the speaker announced that the amendment had failed by a vote of 58 ayes and 38 nays, the ayes not constituting two-thirds of those present and voting.

Shortly thereafter, several members of the House suggested that additional delegates had been seated and called for a reconsideration of the amendment to Chapter VII, Section 8, MSMA By-Laws. There being no discussion, the speaker again called for a standing vote and after the vote the speaker announced that the amendment had failed by a vote of 57 ayes to 47 nays, the ayes not constituting two-thirds of those present and voting.

ANNOUNCEMENT OF NOMINATING COMMITTEE

Following a recess for caucuses by association districts, the Nominating Committee was announced:

J. V. Ferguson, Greenwood, District 1
W. Joseph Burnett, Oxford, District 2
W. H. Preston, Booneville, District 3
Arthur A. Derrick, Jr., Durant, District 4
Hardy Woodbridge, Jackson, District 5
Reginald P. White, Meridian, District 6
James E. Harris, Hattiesburg, District 7
Jim C. Barnett, Brookhaven, District 8
Paul H. Moore, Pascagoula, District 9

Dr. White was elected chairman of the committee which conducted an open meeting on May 5, 1976, and posted the nominations for the information of all members in addition to submitting a written report of nominations to the House of Delegates.

ADDRESS OF THE PRESIDENT

The speaker declared the House of Delegates in open session, and the president, Dr. Jack A. Atkinson of Brookhaven, delivered his address. The address has been published separately in Volume XVII, Number 7, JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, July 1976.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS, COUNCILS, AND BOARD OF TRUSTEES

Your reference committee received the address of our president, Dr. Jack A. Atkinson of Brookhaven. We wish to commend Dr. Atkinson for the content and timeliness of his remarks. The year 1975-76 has been a year of crisis for our profession. Jack Atkinson has served us with distinction and honor during this period and we have indeed been fortunate to have his leadership. He was perhaps best described by a young physician at a dinner in his honor a few weeks ago in Brookhaven. The young physician said that Dr. Atkinson to him "looked like, thought like, and acted like what a physician should be." All of us who know Jack concur in that remark.

In his address Dr. Atkinson specifically recommended that: (1) our Council on Medical Education present a detailed plan to establish continuing medical education as a condition for membership in the association for consideration by the House of

Delegates at the 109th Annual Session; and (2) the association mount an extensive campaign over the next year to communicate the professional liability crisis to the public, said campaign to be funded by a special assessment from the membership. Your reference committee was advised that the latter would amount to $15-20 per member. We concur with and urge adoption of the president's recommendations.

The report of the reference committee was adopted.

SPECIAL ADDRESS

Dr. Max H. Parrott of Portland, Oregon, president of the American Medical Association, addressed the House of Delegates.

REPORT OF THE DELEGATES TO AMA

1975 Annual Meeting. In the most momentous session to be held in decades, delegates at the 124th Annual Convention in Atlantic City urged vigorous AMA action in a number of medical problem areas —including malpractice and federal intervention— and then approved a substantial dues increase to assure the necessary financial support.

Meeting for 22 hours and 37 minutes, the longest convention in recent memory, the House acted on 73 reports and 168 resolutions for a total of 241 items of business.

The AMA House of Delegates emphasized stronger involvement in confronting problems facing local physicians, and voted to raise annual dues to regular members to $250, intern-resident dues to $35, and to maintain student dues at $15.

In his inaugural address on Wednesday, June 18, Dr. Max H. Parrott, the new AMA president, said that "the great national debate on health and medical issues is a clash between (government) utilitarianism and (medical) humanism."

In viewing medical care as a commodity rather than a service, Dr. Parrott said, "the health care planners and regulators see medical care as little more than a numbers game. . . . If only the commodities of health care can be more efficiently organized, assembly-line style, if only the providers of care can be better coordinated as a work force, then the consuming public will be eternally blessed."

In increasing annual dues of regular members from $110 to $250, delegates also served clear notice of a new and aggressive stance by the AMA in dealing with the many problems facing the nation's physicians.

In just one of the problem areas discussed—malpractice—the House called for the AMA to take immediate actions to help ease the crisis, including the formation of an AMA-sponsored professional liability reinsurance company.

The company will provide backup or second-level coverage for those state medical societies that have sponsored their own medical liability insurance programs.

Meanwhile, delegates unanimously endorsed a substitute resolution applauding the recent suit filed by the AMA against HEW regulations which mandate post-admission certification of hospital patients, and left no doubt that a primary reason for approving the dues increase was to provide fiscal support not only for the present suit, but for similar actions as well. Thus the second resolve of the resolution reads:

"That the Board be encouraged to continue to take such action in the future on further legislation or government regulations that threaten the ability of physicians to provide quality medical care to patients."

The House was appraised of the fact that Trustees have instructed the AMA Office of General Counsel to lay the legal groundwork for possible suits against the new federal health planning program, HEW regulations for the proposed "Maximum Allowable Cost" purchase of drugs, and for objectional features of proposed health manpower legislation should those features be enacted.

In other priorities related to the dues increase, the House called for continuing efforts to rebuild the AMA on a sound financial basis, and strongly supported a reshaping of the AMA publishing program as well as a restructuring of the organization itself.

By adopting the $250 dues level recommended by the Board, the House was assured that depleted financial reserves would be restored, that present programs would be continued, and that additional programs—such as those for malpractice and to combat growing government presence—would be mounted. In related actions, the House called for:

—Balanced budgets in both accounting and program formats.

—Intensified membership recruitment and retention efforts.

—Continued administrative support of AMPAC.

—Annual reports on the status of AMA fixed assets and investments.

In other actions, the House urged that the 10 specialty journals be placed on a self-sustaining subscription basis, or that appropriate arrangements be reached with the specialty societies involved.

Upon questioning by trustees, however, the House

made it evident that it will be left to the Board to determine the eventual fate of *Prism,* so long as the disposition is to the financial advantage of the AMA. This interpretation emerged as the result of a special consultants' report to the House on Sunday, June 15, when it was pointed out that AMA publications are valuable properties which should be handled like other association assets.

In short, *Prism* could be sold, or it could be continued if it could be put on a paying basis. The House also authorized the Board to set subscription rates for all publications—including *Today's Health* —excepting only *JAMA* and *American Medical News.*

The House endorsed the concept of restructuring the AMA, including councils and committees, and directed its Council on Long Range Planning and Development to submit a definitive report at this fall's clinical meeting in Honolulu.

Key elements in the report are expected to be the 1975 AMA Plan, and its clustering of AMA priorities into five major areas, organization structure; resolving the malpractice crisis; fighting increased government intervention; maintaining AMA's leadership role in medical education; and strengthening AMA resources.

In response to resolutions from Mississippi and Georgia dealing with Medicare, the House strongly reaffirmed the AMA's long-standing position that physicians participating in government health insurance programs should be reimbursed on the basis of usual, customary and reasonable charges. In a further step, delegates requested the Council on Medical Service to examine the Medicaid and Medicare programs to see if reimbursement did meet AMA policy, and to report back at the Honolulu clinical meeting.

The House also adopted report JJ of the Board, which updates Board actions in objecting to the proposed payment of usual, customary and reasonable Medicare fees based on a national economic index as recently promulgated in regulations published in the *Federal Register.* The Board report emphasized continued and vigorous opposition to the proposal, including legal action should it become necessary.

The House unanimously supported the Board in its recent actions to oppose implementation of the National Health Planning and Resource Development Act enacted by the last congress. The delegates pledged support for "any action, including legal action," that the Board deems appropriate and effective in preventing implementation of the new planning law.

Delegates reaffirmed present AMA policy on PSROs, and defeated a call for repeal of the PSRO law. After discussion in reference committee and on the floor of the House, delegates reaffirmed PSRO policy adopted at the 1974 annual convention.

The policy basically calls for AMA action to seek constructive amendments to the law and appropriate regulations and directives, and to support continued monitoring of the program. The policy also holds that should the PSRO program become too restrictive, however, the Board can seek repeal. And here again, the House cited the possibility of legal opposition if it becomes appropriate.

In other actions related to peer review, delegates urged physicians to "continue to perform peer review directed at increasing the quality of patient care and reducing its cost," and also urged physicians not to seek compensation for non-government peer review participation as established in hospitals. The Board endorsed compensation for government-connected peer review programs, however.

In endorsing a series of proposals aimed at mitigating malpractice problems, the House stressed that the continued ability of physicians to provide care to patients was a prime motivating factor.

While adopting a substitute resolution supporting the use of "all available legal means" by local physicians in seeking reforms in professional liability insurance, for example, it was emphasized that work slowdowns were basically a commitment to continued patient care rather than personal financial gain in the traditional sense of a strike.

The final version of the resolution reads: "The AMA recognizes that physicians are entitled to use all available legal means, without jeopardizing the medical care of their patients, to protest when intolerable and unwarranted burdens are placed upon their patients, the association, or its members." The resolution also recognizes that "the primary commitment of the AMA and its physician members is to the essential medical needs of the people of this nation."

In other actions aimed at easing the malpractice crisis, the House urged renewed AMA assistance to state societies in seeking legislative enactment, and public endorsement of, mechanisms such as voluntary arbitration plans, and changes in tort law to relieve statutory elements which contribute to malpractice problems. The House also reaffirmed its stand against claims-made types of insurance coverage and voted to encourage the federal government

to provide coverage for physicians employed by government.

Delegates supported the national health insurance bill of the AMA which has been introduced in congress. The bill would provide both basic and comprehensive benefits for all Americans, but would minimize federal administration and financing. During a health insurance debate in the House, considerable sentiment was expressed for a national catastrophic insurance coverage program, but the subject was referred to the Board for further study.

Several actions aimed at preserving hospital medical staff prerogatives in patient care were endorsed by the House. A joint report of the Councils on Medical Education and Medical Service provided a detailed study of possible medical staff problems posed by the increasing appointment of salaried chiefs of staff and department heads by hospital governing bodies.

The report pointed out that medical staff rights and prerogatives could be thus shifted to governing boards, and made several recommendations for local medical staffs and medical societies to counter the trend. Delegates adopted the report. The House also endorsed a Board report urging AMA members on the Joint Commission on Accreditation of Hospitals to seek to amend JCAH standards to provide due process for physicians employed in medico-administrative positions.

The House voted to continue opposition to medical manpower legislation now before congress which would require medical students to repay capitation grants to their schools or else provide "in-kind" service in areas stipulated by government, and which would provide federal control of the number and distribution of residencies. At the same time, delegates endorsed efforts to increase the $10,000 maximum limit on federally-insured loans to medical students, and to encourage a continuation of federal support for medical and health manpower programs.

1975 Clinical Meeting. The professional liability insurance crisis and reorganization dominated the Clinical Session of the American Medical Association conducted for the first time in Hawaii.

The Board of Trustees reported on efforts to improve and stabilize the medical liability climate to include incorporation of a national reinsurance company to reinforce the efforts of state "captive programs" to provide professional liability coverage. Additionally, the Board noted the initiation of a major public and professional communications campaign aimed at improving the medical liability climate and announced plans to continue to explore alternatives to the court system for resolving claims. In related action delegates rejected a resolution asking that all physicians cease purchasing professional liability insurance noting that "failure to purchase professional liability insurance exposes a physician to unlimited liability in most states with no apparent legal mechanism available to protect personal assets."

It was back to the drawing board for the AMA's Council on Long Range Planning and Development as most of the council's recommendations for reorganizing the AMA were met with strong rebuff. In a series of 21 recommendations the council urged making the state medical societies—and not the individual M.D.—the basic AMA membership unit; revising the formula for representation in the House of Delegates so that, essentially, the larger states would lose delegates and smaller states would gain, as would the specialty societies, housestaff and students; create a new category of affiliate membership for the national specialty societies and "other" physician organizations; and cutting back to eight standing councils that would report to the Board of Trustees.

The House of Delegates directed that the AMA remain a federation of state medical societies; that proportional representation be maintained; that the specialty councils be retained; and that the eight standing councils report to the house, not the board.

Of particular interest to Mississippi was a Council on Medical Service report announcing that the council would study and report at the 1976 Annual Session on the effect Medicare and Medicaid reimbursement policies have on distribution of physicians. The council's activity in this regard was based on a resolution from Mississippi at the 1975 Annual Session calling for more equitable reimbursement under Medicare between the states. In other related action concerning the Medicare and Medicaid programs the House strongly criticized the use of "economic indexing" to limit fees to physicians treating Medicare patients and called for deletion of patient and physician names and Social Security numbers from the Social Security Administration's Uniform Health Data Abstract.

A controversy at Chicago's Cook County Hospital echoed in Hawaii and the House of Delegates voted down a resolution to have the AMA investigate the issues surrounding an 11 day housestaff strike. The Interns and Residents Session had approved the resolution. However, after testimony from officers of the Chicago Medical Society that the society had investigated the matter thoroughly and found no justification for the strike, the House disapproved

the resolution. On a similar matter the House of Delegates recognized the right of interns and residents to do collective bargaining stating that interns and residents are both employees and students and thus should have the right to organize and bargain for contracts with hospitals. The House further urged state and county medical societies to assist or represent interns, residents and attending physicians in resolving disputes with hospitals.

The House turned back an attempt to withdraw support from the AMA-sponsored national health insurance (NHI) plan, but agreed to work for a private-sector catastrophic health insurance program with the insurance industry. The Louisiana delegation introduced a resolution to withdraw support from H.R. 6222, the AMA sponsored health insurance plan, stating that most delegates were opposed to any form of NHI. Many delegates agreed, but said that AMA's strategy should be to support an acceptable plan to help defeat mandatory, federally funded proposals.

In other actions the House of Delegates acted to expand AMA legislative action efforts to include participation by state and county medical societies; refused to adopt recommendations from the Medical Student Business Session that the AMA support both elimination of capitation and adoption of a voluntary service linked financial aid program for all medical students; established an ad hoc committee to undertake a crash program to investigate medical discipline nationwide; supported enactment of less restrictive federal regulations governing the performance of voluntary sterilization paid for by the Medicaid program; urged state and local medical societies to work with appropriate local health planning bodies to assist rural communities in a logical service area to coordinate and share their health resources on a regional basis; and stated that compensation of physicians for utilization review of inpatient care is a legitimate expense and should be included in all hospital rates and reimbursable costs regardless of who is paying the patient's bill.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS, COUNCILS, AND BOARD OF TRUSTEES

Your reference committee received the report of our Delegates to the AMA covering activities of the AMA House of Delegates at its 1975 annual and clinical meetings. We recommend the report to the attention of all members and commend our delegates for their activities in our behalf.

The report of the reference committee was adopted.

REPORT OF THE COUNCIL ON SCIENTIFIC ASSEMBLY

Organization and Duties—The Council on Scientific Assembly is a constitutional body of the House of Delegates charged with the responsibility of planning the annual session of the association to include all scientific activities, programming, and the scheduling of annual session events. The council membership consists of the chairmen and secretaries of the nine scientific sections and the secretary-treasurer of the association, a total of 19 members.

108th Annual Session—Planning and organization of the 108th Annual Session was initiated in the summer of 1975. The condensed format conducted at the 107th Annual Session will be continued this year which means that the final session of the House of Delegates will again meet on Thursday morning and several scientific sections will meet simultaneously. To the extent possible, conflicts in schedules and programming have been eliminated, although as a practical matter, such total elimination is not possible. In some instances, the council has requested and placed essayists from various specialty societies not represented in the scientific assembly before section audiences. Postgraduate credit from the AMA and American Academy of Family Physicians has been applied for.

We are gratified that at the present annual session, numerous specialty societies have related or concurrent meetings with us. Three medical alumni groups have fraternal and social occasions during convention week, and various nonscientific but medically related bodies will meet during May 3-6. Added postgraduate attractions this year include a Sunday afternoon urology seminar and a Monday dermatological program. We continue to believe that providing for and encouraging these related meetings increases the attractiveness of the annual session to the membership and benefits attendance. We are glad to continue support of the Auxiliary concurrent annual session, and the Auxiliary will again host the hospitality booth on Sunday afternoon to greet and welcome convention goers.

The council voted to return to the previous MSMA party format which included social hour, dinner and entertainment. It was decided to hold the MSMA fellowship party on Tuesday night, May 4. Entertainment will be the Gaslight Road Show from Chicago.

Scientific and Technical Exhibits—Your council

is grateful for the participation of our scientific and technical exhibitors in this 108th Annual Session of the association. Presentations in the scientific exhibit number over 15 this year. We urge every member and guest to view these educational exhibits and the technical exhibits.

Headquarters Hotel—The annual session will be held at the all new Holiday Inn Downtown. The luxurious convention center boasts a whole second floor of 15 meeting rooms, 360 guest rooms, restaurant and lounge. The hotel is located in the heart of Jackson next to the new Deposit Guaranty Plaza. The council is directing an extensive promotional campaign through the JOURNAL MSMA and the Blue Sheet to increase attendance at the annual meeting.

Expression of the Council—Your Council on Scientific Assembly is grateful for the support, cooperation and assistance we have received in planning the 108th Annual Session.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS, COUNCILS, AND BOARD OF TRUSTEES

Your reference committee received the annual report of our Council on Scientific Assembly. We commend the council for its work and efforts in planning this 108th Annual Session. We especially commend the chairman of the council, Dr. Jim Spell of Jackson.

The report of the reference committee was adopted.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

Organization and Duties—The Council on Medical Service is a constitutional body of the House of Delegates consisting of nine members, one from each association district, elected for terms of three years each. The council is charged with the responsibility of ascertaining and studying all aspects of medical care in Mississippi. Under the council's jurisdiction are assigned activities of the association in medical service, emergency service programs, medical care for the indigent and the work of allied medical agencies and organizations. The work of the council and its several committees during the 1975-76 association year are included in this report.

Committee on Nursing—The Committee on Nursing continues to serve as the association's representatives on the MSMA-Mississippi Nurses Association Joint Practice Committee. Primary work before the committee has been study and recommendation concerning the expanded role for the RN approved by the House of Delegates and authorized by statute in 1974. During the year, members of the committee participated in a statewide nursing education conference and attended the meeting of the National Joint Practice Commission. The committee also monitored and attempted to communicate to the State Board of Nurses the medical profession's views and concerns about actions of the board dealing with LPNs.

Committee on Maternal and Child Care—The Committee on Maternal and Child Care continued its study of maternal deaths occurring in Mississippi. A report on the committee's study of maternal deaths occurring in 1972 was published in the December 1975 issue of the JOURNAL MSMA. The committee continues to distribute its "Maternal Health Desk Cards" which serve as a handy reference source of maternity care. Members of the committee are also serving on a new *ad hoc* Committee on High Risk Maternal and Newborn Care whose activities are reported elsewhere by the council.

Committee on Mental Health—Materials on the state's commitment laws as revised by the 1975 legislature were distributed to all MSMA members by the Committee on Mental Health during the past association year. The council expressed concern last year about the possibility of a non-M.D. director being named to replace the then M.D. director of the Mississippi Department of Mental Health and is happy to note that this did not occur.

Committee on Blood and Blood Banking—This committee of the council has not been active for several years. Based on recent activities and interest in this important medical service area on both the national and local level, the council plans to activate the committee during the 1976-77 association year. The committee will be charged with the responsibility to study and report on all proposed and operational aspects of blood banking and blood service.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS, COUNCILS, AND BOARD OF TRUSTEES

Your reference committee received the annual report of our Council on Medical Service. The activities of the council and its several committees are reported therein. We commend the work and activities of the council.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT A OF THE COUNCIL ON MEDICAL SERVICE

The Council on Medical Service is charged with

the responsibility of ascertaining and studying all aspects of medical care in Mississippi. Within this context the council has reported the ongoing activities of its several constitutional committees during the 1975-76 association year in the *Handbook of the House of Delegates*. The council has received other subject matters within its sphere of assigned interests and wishes to bring the following information and recommendations to the attention of the House of Delegates for such action as deemed appropriate.

Committee on High Risk Maternal and Newborn Care (Ad Hoc). The American Medical Association, American Academy of Family Physicians, American Academy of Pediatrics and American College of Ob-Gyn have urged the formation of statewide committees on high risk maternal and newborn care to:

a. evaluate at both state and regional level current patterns in the management of high risk maternal and newborn care;

b. determine what facilities and personnel are currently available for high risk care;

c. make recommendations for the future planning of such care; and

d. establish a mechanism for the continuing evaluation of the effectiveness of planning and of patient care in this area.

Acting on this request, MSMA president Jack Atkinson, appointed an *ad hoc* committee last fall to begin work in this important area of interest. The committee has met several times over the past few months and at this time the following priorities have been established by the committee with respect to its program of work:

a. accurately assess mortality rates of maternal and newborn patients in Mississippi;

b. survey local needs and resources for high risk maternal and newborn care in Mississippi and define results caused by proper medical care not being available;

c. study nationally developed (i.e., AMA and specialty organizations) and locally developed guidelines for high risk maternal and newborn care;

d. establish a statewide model for providing high risk maternal and newborn care based on needs and resources;

e. establish priorities for providing high risk maternal and newborn care.

The committee has sought representation from all professional groups concerned with high risk maternal and newborn care in our state. Members of the committee plan to meet with concerned specialty groups during this 108th Annual Session of the association to discuss the committee's activities and to seek guidance in this regard. Physician members of the committee are: Dr. Wendell H. Stockton, Amory, chairman; Dr. John E. Rawson, Jackson; Dr. Frank M. Wiygul, Jr., Jackson; Dr. Daniel H. Draughn, Jackson; Dr. J. Purves McLaurin, Oxford; Dr. W. E. Godfrey, Natchez; Dr. Donald M. Sherline, Jackson; Dr. Thomas R. Singley, Pascagoula; and Dr. John D. McEachin, Meridian.

Rural Health Services. Issues related to the geographic and specialty distribution of health manpower in rural areas are receiving increased attention. Various proposals which would in effect conscript physicians for medically underserved areas have increased on both the national and state level. The purpose of this report is to review briefly for the House of Delegates the progress made in alleviating maldistribution of health services through voluntary methods and to recommend those approaches which merit increased emphasis in Mississippi.

Recent studies have given increased support to the hypothesis that medical students from a rural background are more likely to establish practice in a rural area. Other studies have also strongly suggested a relationship between rural preceptorship experience and subsequent selection of a rural practice site as well as a greater tendency for physicians specializing in family practice to seek a rural rather than an urban practice. Accordingly, the council wishes to recommend that the association support efforts by those concerned in Mississippi which give increased attention in the selection process for medical students to applicants from rural areas and which give continued and increased support to family practice and emphasize rural preceptorships and other mechanisms to give medical students an experience with rural practice.

The council also wishes to direct the House of Delegates' attention to increased emphasis on voluntary inter-community cooperation in providing health services for medically underserved areas. The council encourages the process of area wide sharing of such health resources as emergency medical services.

Swine Influenza Vaccination Campaign. A nationwide campaign has been announced to vaccinate every American this fall against the swine influenza A virus. The nation has never attempted an immunization program of such scope and intensity. The

campaign will require major cooperation between the public and private sectors. The House of Delegates, after due consideration of this subject in reference committee, should arrive at a recommended course of action for the association and its component societies to support the swine flu vaccination program in Mississippi in cooperation with the Mississippi State Board of Health.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS, COUNCILS, AND BOARD OF TRUSTEES

Your reference committee considered Supplemental Report A of the Council on Medical Service. The report reviews formation of a new association Committee on High Risk Maternal and Newborn Care, reports on the council's review of issues related to geographic and specialty distribution of health manpower in rural areas and urges the association to consider a course of action to support the swine flu vaccination program in Mississippi in cooperation with the Mississippi State Board of Health.

Your reference committee commends formation of the Committee on High Risk Maternal and Newborn Care. We further urge adoption of the council's recommendations that the association support efforts by those concerned in Mississippi which give increased attention in the selection process for medical students to applicants from rural areas and which give continued and increased support to family practice and emphasize rural preceptorships and other mechanisms to give medical students an experience with rural practice.

The report of the reference committee was adopted.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

Council Activities—The council is assigned responsibility for work in the areas of medical education, licensure and facilities for medical education. During this past year the council has continued to emphasize organization and accreditation of instate continuing medical education programs for physicians as authorized by the House of Delegates in 1973. In this connection the council, with the approval of the Board of Trustees, sought and received a grant from the Mississippi Regional Medical Program to conduct a survey of CME programs for physicians in Mississippi leading toward periodic publication of a "Directory of CME Programs for Physicians." The council will present a report on the results of the survey when it is completed.

Preliminary results of the council's CME survey strongly indicate the desire of medical specialty societies, organizations and hospitals to establish CME programs for physicians which will meet accreditation requirements. Such programs are based on identified needs. One of the council's main goals during the 1976-77 association year will be to assist interested medical staffs, specialty societies and organizations in establishing local CME programs that meet accreditation requirements.

Based on mutual interest and cooperation, the council is happy to note its designation as the Continuing Education Committee of the Mississippi Foundation for Medical Care—PSRO during this past year. In its dual role the council believes that it can more effectively respond to requests for CME technical assistance and more effectively coordinate CME activities of joint interest to both MSMA and the MFMC. The medical audit resources and activities of the MFMC-PSRO are prime examples of this process.

In its efforts to encourage CME attendance by physicians and recognition of such attendance, the council will implement a program shortly after this annual session to annually report CME courses attended by members of the association. Under this program, which will be conducted in our MSMA office, members of the association may individually report by telephone or mail their CME attendance and hours. Such members will then annually receive a report on such attendance and hours which may be used to complete application for the "AMA Physician's Recognition Award" and/or CME membership requirements for the American Academy of Family Physicians. Full details of this project will be mailed to members of the association shortly after the annual session.

Accreditation of MSMA Annual Session—Under guidelines of the American Medical Association's Council on Medical Education the council has proceeded to accredit the Council on Scientific Assembly of the Mississippi State Medical Association. Such accreditation will mean that the scientific program of the MSMA annual session may be recognized as meeting Category I requirements for the "AMA Physician's Recognition Award." Initial and periodic accreditation of the Council on Scientific Assembly will be conducted by the Council on Medical Education and this has raised a conflict with respect to action taken at the 107th Annual Session proposing a change in the composition of the Council on Medical Education at this 108th Annual Session. This matter will be discussed in a report to the House but essentially the problem arises from

changes making the council on Medical Education elected by the scientific sections of the association. The scientific sections also elect the Council on Scientific Assembly and this means that the association's accreditation body (the Council on Medical Education) would be elected by the same groups which elected the association's scientific programming body (the Council on Scientific Assembly). Under such an arrangement the Council on Medical Education would not be able to accredit the Council on Scientific Assembly because the two are not structured totally separate as required by AMA "Guidelines" for accreditation. The Council on Medical Education would in effect be reviewing and accrediting its own scientific program and work.

Council Committees—As part of its accreditation procedure the council seeks volunteers to serve on "CME survey teams." The council would like to especially recognize and express its appreciation to the members of the association who have devoted time to serve on these teams during the past year.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS, COUNCILS, AND BOARD OF TRUSTEES

Your reference committee received the annual report of our Council on Medical Education. The report notes the success of the council in encouraging organization of continuing education programs for physicians in Mississippi which meet accreditation requirements. The council also reports plans to establish a mechanism within our state office for members of the association to report CME attendance which will be annually reported back to them. We commend the work and activities of our council.

The report of the reference committee was adopted.

REPORT OF THE BOARD OF TRUSTEES

Organization and Duties—The Board of Trustees is the executive and governing body of the association during vacation of the House of Delegates. It is additionally charged with duties and responsibilities prescribed by law for directors of corporations. In the discharge of these duties the Board shall have conducted four meetings during the 1975-76 association year and met daily during the annual session as required by the association's by-laws. Eight officers sit with the Board of Trustees at all meetings. They are the president, president-elect, immediate past-president, secretary-treasurer, speaker, vice-speaker and the two AMA delegates. Based on action by the House of Delegates at the 107th Annual Session, the Board was expanded this past year to include an additional trustee from District 5 and the president and immediate past-president.

This annual report includes actions on matters referred to the Board by the House of Delegates and items relating to the management and policy functions which are among the Board's responsibilities.

Referrals from the House of Delegates—Matters referred to the Board of Trustees at the 107th Annual Session, 1975, and actions by the House requiring further consideration and implementation include:

(1) Amendments to the MSMA Constitution and By-Laws. An amendment to the MSMA Constitution and By-Laws dealing with equalization of MSMA membership within association districts is "on the table" for action at the 108th Annual Session. Copies of the amendment were furnished to all component medical societies 60 days prior to the annual session as required by the constitution and by-laws. Another amendment scheduled to be considered at the 108th Annual Session deals with composition of the Council on Medical Education. Both amendments are the subject of a report from the Council on Constitution and By-Laws.

The following amendments to the MSMA Constitution and By-Laws adopted at the 107th Annual Session have been implemented:

(a) Nominees for election to office will have attended one of the past two or current annual sessions.

(b) Two trustees are elected to the Board of Trustees from District 5.

(c) The president and immediate past-president are voting members of the Board of Trustees.

(d) Trustees and council members will serve no more than two consecutive three-year terms and after serving six consecutive years are ineligible for re-election to the same body for six years.

(e) A Section on Radiology has been established as one of the scientific sections of the association. The association now has scientific sections on Ob-Gyn, Medicine, Surgery, Family Practice, Preventive Medicine, Pediatrics, EENT, Anesthesiology and Radiology.

(2) Physicians Professional Liability Insurance Program. In "Supplemental Report E—Physicians Professional Liability Insurance Program" the Board and the Committee on Professional Liability Insurance recommended and the House of Delegates approved an extensive legislative program to change the malpractice legal system and study of alternatives to the liability insurance market. Both of these recommendations were the subjects of a special called session of the MSMA House of Delegates on Oct. 23, 1975, the transactions of which are reported in the April 1976 issue of the JOURNAL MSMA.

(3) Chiropractors. In "Supplemental Report C of the Board of Trustees—Chiropractors" the Board recommended and the House of Delegates approved that the association initiate necessary legal action to terminate apparent practices of chiropractors in the state which violate provisions of the chiropractic licensing act and result in the practice of medicine without a license to the detriment of the public's health. Based upon contributions from some 900 MSMA members, legal action in this regard was initiated and the case is presently in the court.

(4) Resolution No. 4—Equalize Payment for Physicians' Services Under Medicare. This resolution urged MSMA and the American Medical Association to go on record as supporting the adjustment of payment of professional fees under the Medicare program to make such fees more equal between Mississippi and other states. The resolution was introduced at the June 1975 meeting of the AMA House of Delegates by our Mississippi delegates and after amendment the following resolution was adopted by the AMA—*"Resolved,* that the AMA reaffirm its long-standing position that government programs which pay for physicians' services should base their payment on physicians' usual, customary and reasonable charges; and be it further *Resolved,* that the Council on Medical Service examine Titles XVIII and XIX to determine the status of these programs with respect to their paying physicians' usual, customary and reasonable charges and the effect, if any, their reimbursement policies are having on the distribution of physician. . . ." The latter resolve was specifically added by our Mississippi delegates after it became apparent that the AMA House of Delegates was not going to amend its policy on physician reimbursement based on "usual, customary and reasonable charges" and the report of the AMA Council on Medical Service will be made at the AMA June 1976 meeting.

(5) Resolution No. 5—Medical Public Relations Program. This resolution directed the association to furnish guidance and urge each of the component medical societies to establish meaningful contact with the local press to implement a medical public relations program. A letter was sent to the president and secretary of each component society urging them to establish a committee on medical public relations. A "How to Establish a Media Relations Program" booklet was also furnished to the component societies and we have offered the assistance of MSMA staff in this regard.

(6) Resolution No. 7—Inclusion of Coverage of Psychiatric Disorders in Health Insurance Policies. This resolution directed the association to support legislation requiring inclusion of coverage of psychiatric disorders in health insurance policies sold in Mississippi and is a subject in a report from the Board concerning 1976 legislative activities.

(7) Resolution No. 12—Reaffirmation of Position Relative to Use of Drugs by Optometrists. This resolution reaffirmed the association's opposition to legislation permitting the use of drugs by optometrists and is a subject in a report from the Board concerning 1976 legislative activities.

(8) Compensation of Elected MSMA Officers and Strengthening the Component Societies. Based on study and recommendation by a special committee the House of Delegates directed the following at the 107th Annual Session concerning compensation of elected MSMA officers and strengthening the component societies:

1. MSMA will provide speakers for component medical society meetings to present medical socioeconomic subjects desired by the society.

2. MSMA will provide clerical assistance with respect to sending out meeting notices for any component society that requests such assistance.

3. Upon request, MSMA will assist the component medical societies in arranging meetings or programs that offer continuing medical education accreditation for those in attendance.

4. MSMA will sponsor an annual workshop at meetings of the association for all component medical society presidents and secretaries to discuss the role of the component medical society and areas for strengthening that role.

5. Each MSMA trustee is encouraged to annually visit the component societies in his association district.

6. Each component medical society is encouraged to conduct an annual "legislative night" for the purpose of discussing health care issues with local members of the Mississippi legislature.

7. MSMA will provide all component society officers with a complete summary of action by the House of Delegates following each annual session.

8. The president, president-elect, vice presidents and secretary-treasurer will be reimbursed for travel expenses incurred in visiting the component societies.

9. The president's honorarium is increased from $1,000 to $1,500.

Items 1-6 were conveyed to the president and secretary of each component society by personal letter and in this connection a form was enclosed for the component society to use to invite the district trustee to a meeting of the society. Item 7 was forwarded to the president and secretary of each component society immediately following the 107th Annual Session. Items 8-9 have been implemented as MSMA fiscal policy.

CHAMPUS—The association began its 20th year as fiscal administrator for CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) in 1976. CHAMPUS, which is directed by the Department of Defense, implemented dramatic cutbacks in benefits and professional reimbursement procedures during the past year for announced reasons of budget constraint. Of particular concern to the medical profession effective Jan. 1, 1976, the program began reimbursing participating physicians at the 75th percentile of usual, customary and reasonable charges in a state. The program had been making payment based on the 90th percentile. A 14-member physician committee serves as the review committee for CHAMPUS in Mississippi. The program continued to grow during 1975 with an increase in both claim and dollar volume.

Insurance Programs—The association continues to sponsor a professional liability insurance program with the St. Paul Companies and general accident, disability, health and life programs with the Continental Casualty Company. The latter is administered by Thomas Yates and Company of Jackson. The Board monitors the several programs.

Legislative Program—A new state administration was inaugurated in Jackson during January 1976. The Council on Legislation has met several times over the past months for the purpose of organizing and monitoring the association's legislative program. The program dealt with the professional liability insurance crisis and other matters based on prior actions of the House of Delegates. A full report will be made in this regard at the annual session.

Public Law 93-641—Public Law 93-641, the "National Health Planning and Resources Development Act of 1974" was the subject of a report to the House of Delegates at the 107th Annual Session. Implementation of this law has proceeded during the past year in Mississippi and other states. Public Law 93-641 combines and expands the health planning and funding functions of the Regional Medical, Comprehensive Health Planning and Hill-Burton programs. Criticism of the law has been directed at its apparent placing of complete control of health planning and funding prerogatives in the hands of the Secretary of H.E.W. and the placing of administrative responsibility for carrying out the Secretary's guidelines and directives in this regard in the hands of "consumer" dominated boards.

In Mississippi during the past year two private corporations were formed and competed for designation as the state's Health System Agency under Public Law 93-641. They were the Mississippi Health Improvement Corporation and the Mississippi Health Systems Agency. Based upon careful consideration of the two applicants' credentials and stated plans for operation, the Board accepted an invitation from the Mississippi Health Improvement Corporation to endorse its application for funding as the Health Systems Agency for Mississippi. The Health Systems Agency for Mississippi will more than likely be designated by the Secretary of the H.E.W., after consideration of the governor's recommendations in this regard, by the time of the MSMA annual session.

In addition to the Health System Agency for Mississippi, Public Law 93-641 requires a "State Health Planning and Development Agency" for the state. This is to be a state agency designated by the governor with the approval of the Secretary of H.E.W. At this time a number of state agencies and the Governor's Office of Comprehensive Health Planning have been mentioned as the State Health Planning and Development Agency. Regulations and

guidelines governing the operations of "State Health Planning and Development Agencies" have not been issued by the Secretary of H.E.W. and there is merit in awaiting these before a State Planning and Development Agency is named. After careful consideration of the credentials and present operational capacity of the several state agencies mentioned as potentially qualified to be the State Health Planning and Development Agency, the Board has recommended that the Mississippi State Board of Health be designated this agency.

MSMA/Mississippi Bar Association Liaison Committee—The Board is pleased to note the reactivation of the MSMA/Mississippi Bar Association Liaison Committee during the past year. This committee conducted very important and meaningful work on professional liability legislation. The committee has encouraged activation of local physician/attorney committees for the purpose of discussing matters of mutual concern and we wish to encourage implementation of this recommendation by the component societies of the association. The committee will undertake a reappraisal and updating of the "Mississippi Interprofessional Code for Physicians and Attorneys" as its next project. Members of the committee during the past year were: Jack A. Atkinson, Co-chairman, Brookhaven; Lyne S. Gamble, Greenville; Charles R. Jenkins, Laurel; Sidney O. Graves, Natchez; George D. Purvis, Jackson; Martin B. Harthcock, Jr., Jackson, physicians; and Curtis Coker, Chairman, Jackson; Dixon Pyles, Jackson; Ernest W. Graves, Laurel; Louis G. Baine, Jackson; Lampton O. Williams, Poplarville; Alfred E. Lee, M.D., Oxford, attorneys.

History of the Mississippi State Medical Association—The Board has previously announced plans to update and publish a new edition of the "History of The Mississippi State Medical Association." The history is to be published during this "Bicentennial Year." It will be a memorial to the late Dr. James Grant Thompson of Jackson, a former president of the association and author of the last edition of the "History of the Mississippi State Medical Association."

Annual Registration of Physicians' Licenses—During the past year the Board officially expressed concern to the Mississippi State Board of Health about the implementation of Section 73-27-12, Mississippi Code 1972, Annotated. It had been the Board's impression that this statute provided for the annual registration of physicians' licenses as opposed to annual renewal of such licenses. The Board is happy to report the concurrence of the Mississippi State Board of Health in this view.

Gulf Coast Family Health Foundation—Based upon a study by the Singing River Medical Society and request for association support the Board joined the society in opposing funding of an initial development grant (HMO) for the Gulf Coast Family Health Foundation last year. The Board is happy to note that based on opposition to this project the sponsors withdrew their application.

Committee on Peer Review—The Committee on Peer Review is a constitutional committee of the association charged with the work of peer review . . ." including but not limited to resolution of differences between patient and physician, review of the quality of medical care, adequacy and/or reasonableness of fees, whether due or paid from private or public sources, utilization of health care resources and liaison with private and public sources of medical care financing. . . ." During the past year the committee conducted its routine functions and also at the request of the Mississippi Medicaid Commission conducted peer review of the quality and efficiency of services provided by physicians receiving more than $100,000 annually in Medicaid payments. Coincidently, the timing of the committee's Medicaid review project coincided with adverse national publicity concerning Medicaid payments to physicians and the release of the annual Mississippi Medicaid Commission's report concerning payments to health providers. The committee's report on the medical review project was generally favorable and had a positive effect on Medicaid publicity concerning payments to physicians in Mississippi. The Board wishes to particularly bring the work of this committee during this past year to the attention of the House of Delegates. Members of the committee have devoted many hours to work that has benefitted both the medical profession and the public in Mississippi. Members of the committee are: Ralph L. Brock, Chairman; William B. Hopson, Jr.; Richard C. Fleming, Jr.; James M. Dabbs; J. Kinabrew Williams; Bobby F. King; James V. Ferguson, Jr.; John R. Lovelace; Paul E. Mink; and Ex-Officio members—Jack A. Atkinson and Lyne S. Gamble.

Mississippi Foundation for Medical Care—The Mississippi Foundation for Medical Care became a fully operational "Conditional PSRO" during June of 1975. The association maintains close liaison with the MFMC and serves under contract as the data processor for the MFMC. The MFMC will hold its

annual membership meeting in conjunction with the 108th Annual Session.

Mississippi Medical Political Action Committee (MPAC)—Based on action by the House of Delegates at the 106th Annual Session, MPAC supported candidates for state office during the 1975 Mississippi elections. Seventy-five per cent of the legislative candidates supported by MPAC were elected. Candidates were supported based on local support and/or their voting record during the 1972-1976 Mississippi Legislative Session. MPAC continued to grow in membership during 1975.

Committee on Publications—THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION concluded its 16th year of continuous publication in 1975. The content of the JOURNAL MSMA continues solidly around Mississippi medicine and the journal serves as the association's prime communication mechanism with the membership. Usefulness of the journal was confirmed by favorable results of a membership survey conducted in the fall of 1975. The survey shows that some 75 per cent of the membership read the journal on a regular basis. Readers indicated a desire for more practical scientific articles and more MSMA news. We will meet this request.

Total pages in Volume XVI, 1975, were down from 1974 reflecting fewer national ads and continuing efforts to produce a smaller book to try to cut printing and postage costs. These efforts plus an increased amount of local advertising have helped to offset increasing printing and paper costs. The Committee on Publications voted at its annual meeting to raise the rates for national advertising by 10 per cent to bring JMSMA rates in line with other southern states and to generate additional revenues.

Among services the journal provides the membership are: complete program of the annual sessions; handbook and proceedings of the House of Delegates; and regular listing of component medical society officers and meeting dates.

The Board wishes to acknowledge special appreciation to the editors and the Committee on Publications in the production of this vital membership service.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS, COUNCILS, AND BOARD OF TRUSTEES

Your reference committee considered the annual report of our Board of Trustees published in the *Handbook of the House of Delegates*. Our trustees have handled a wide range of activities on our behalf this past year and we commend them for their efforts in this regard. During discussion of the Board's report it was specifically recommended that we educate the public about health quackery. We concur with this recommendation with respect to the merits of individual physicians discussing this subject with their patients. Health quackery, however, often results in the practice of medicine without a license. We think the association should seek litigation to stop such activity when it occurs.

Your reference committee concurs with the annual report of our Board of Trustees.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT A OF THE BOARD OF TRUSTEES

Legislative Activities, Background—The 147th Session of the Mississippi Legislature convened in Jackson on January 6, 1976, for its first 120 day regular session of the 1976-1979 legislative term. The Council on Legislation held three meetings during this legislative session and reported to the Board of Trustees at its December and March meetings in this regard. In accordance with prior directives of the House of Delegates, the council directed weekly publication of the Mississippi Medical Legislative Report and again operated an Emergency Medical Care Unit at the Capitol.

1976 MSMA Legislative Program—In addition to monitoring all health related bills which were introduced in the 1976 Legislative Session, the association had a nine-point legislative program to deal with the professional liability crisis. These nine proposals, which were based on positions adopted by the House of Delegates at the 107th Annual Session and the October 1975 Special Session, were: (1) provide for disciplinary action against any physician who exhibits gross incompetency in the practice of medicine; (2) require that any malpractice claim be reviewed by a panel of one attorney, three physicians, and two members of the general public before a lawsuit could be filed; (3) reduce the statute of limitations on malpractice claims to two years for adults and two years after the age of four for minors; (4) codify our existing Mississippi Supreme Court ruling on the utilization and validity of informed consent; (5) provide for an implied waiver of the medical privilege as to all treating physicians when a malpractice suit is filed; (6) provide immunity for actions of peer review committees and individuals who provide information to these committees; (7)

authorize the Insurance Commission to establish a Joint Underwriting Association to write professional liability insurance should such coverage be unavailable on the commercial market; (8) codify Mississippi's existing law regarding the burden of proof and locality rule in malpractice cases; and (9) permit the introduction of evidence regarding collateral payments in a malpractice case. It should be noted here that these nine proposals represented the most far-reaching and controversial legislative program the association has possibly ever undertaken, since nearly all of these bills in some way dealt with the judicial process, or the legal environment, rather than health care. A summary of the status of these proposals is discussed below:

1. *Provide for Disciplinary Action Against any Physician who Exhibits Gross Incompetency in the Practice of Medicine*—this proposal was introduced in both houses of the legislature. The Senate version was never reported out of the Senate Public Health Committee while the House version was reported favorably by the House Public Health Committee. The House bill, however, was placed on the noncontroversial calendar and when it was declared controversial by 15 members of the House it was moved to the bottom of the general calendar where it could not be acted on prior to adjournment on the deadline for passing bills in the house of origin. A latter plan to amend a Senate passed bill in the House to incorporate this proposal was cut short when the House adjourned before reaching the bill on the deadline for passing bills originating in the opposite house.

2. *Require all Malpractice Claims to Be Screened by a Panel of One Attorney, Three Physicians and Two Members of the Public Before Suit Can Be Filed*—this proposal was also introduced in both houses of the legislature. The Senate version was never reported out of committee by the Senate Judiciary A Committee while the House version was reported by the House Judiciary A Committee, but with an amendment which made the panel review optional with the plaintiff rather than mandatory. The bill passed the House in this form, was sent to the Senate and died in the Senate Judiciary A Committee because they felt that on an optional basis the review would do more harm than good and they did not want to make it mandatory. The failure of this proposal can be attributed to the fact it represents such an extreme departure from the customary method of seeking legal redress that the legislature did not want to require a pre-trial review in the absence of some overriding proof that the process will do what it is intended to do—reduce nuisance or nonmeritorious claims. Due to the fact that even those states which have enacted mandatory review of claims do not yet have any convincing evidence of how beneficial this review is the legislature was hesitant to adopt this law without such information or data.

3. *Reduce Statute of Limitations on Malpractice Claims to Two Years on Adults and Two Years after the Age of Four for Minors*—this proposal was also introduced in both houses of the legislature. The House version died in the House Judiciary A Committee, while the Senate version was reported by the Senate Judiciary A Committee with a four-year statute of limitations on adults and no change in existing law regarding minors. When the bill came up for a vote in the Senate an amendment was offered setting the statute of limitations on minors at four years after the age of six, but the amendment was defeated by a fairly large margin. The Senate bill was then sent to the House where the House Judiciary A Committee reported it out with a two-year statute of limitations on adults and minors after they reach the age of 21. The bill ultimately passed the House in this fashion and at this writing it is in a joint House-Senate Conference Committee. It must be noted here that considering the legislature's reaction to applying the statute of limitations to a minor before they reach the age of 21, this will be an extremely difficult thing to accomplish, particularly in view of the fact that 48 of the states have laws similar to ours with regard to minors.

4. *Codify the Existing Mississippi Supreme Court Rule on Informed Consent*—this proposal was also introduced in both houses of the legislature and died in the Judiciary A Committee of both the House and Senate. This was an attempt to codify our Supreme Court's ruling on informed consent in previous malpractice cases where it has been an issue. This is probably the best interpretation of informed consent in the country as far as physicians are concerned. The vast majority of the legal profession, however, frowns upon making "rules" of law statutory since they are ordinarily made by the courts in previous cases, and as such are subject to being expanded or overruled. By making these "rules" statutory they can only be changed by the legislature and not by the courts, thus denying a lawyer the opportunity of "making law" by arguing successfully before the Supreme Court. On the positive side, however, is the fact that nearly all legal experts agree that it is more difficult to get the courts to change one of their "rules" of law than it is to get the legislature to

change theirs. With this thought in mind perhaps we can expect our excellent ruling on informed consent to stand for some time.

5. *Grant an Implied Waiver of the Medical Privilege When a Malpractice Suit Is Filed*—this proposal was also introduced in both houses of the legislature. It was later adopted by both the House and Senate and signed into law by Governor Finch on April 19. It should be noted here that many lawyers, legislators and others feel that this bill will have the most positive effect on defending and reducing malpractice claims than any of the other eight proposals.

6. *Provide Statutory Immunity for Peer Review Committees and Persons Who Furnish Information to those Committees*—this proposal was introduced in both the House and Senate and both chambers passed their version of the bill although neither acted on the other's version after it had initially been passed. Thus, the proposal died for this session. This was due in large part to the fact that activities of peer review committees since they are primarily concerned with protection of the public interest, have been considered privileged by the courts and immunity has constantly been extended to protect them even though there is no particular statute specifically extending that immunity.

7. *Authorize Insurance Commission to Establish Joint Underwriting Association to Write Professional Liability Insurance on an Emergency Basis*—this proposal was also introduced in both houses of the legislature. The Senate version was adopted early in the session and sent to the House where it was also passed in a different form. At this writing the bill is before a joint House-Senate Conference Committee where a compromise version will be worked out.

8. *Codify the Mississippi Supreme Court's Ruling Regarding the Burden of Proof in a Malpractice Case*—this proposal was also introduced in both houses of the legislature. Although the Senate version was adopted and sent to the House it was not acted on there and it died for this session. The same difficulties which were noted earlier about enacting a law regarding informed consent also apply to this bill since it was an attempt to make a "rule" of law in previous cases statutory. Again on the positive side, however, as noted previously with informed consent the court is very hesitant to change one of its own "rules" of law and it is very likely that our excellent rule regarding the burden of proof will stand for some time.

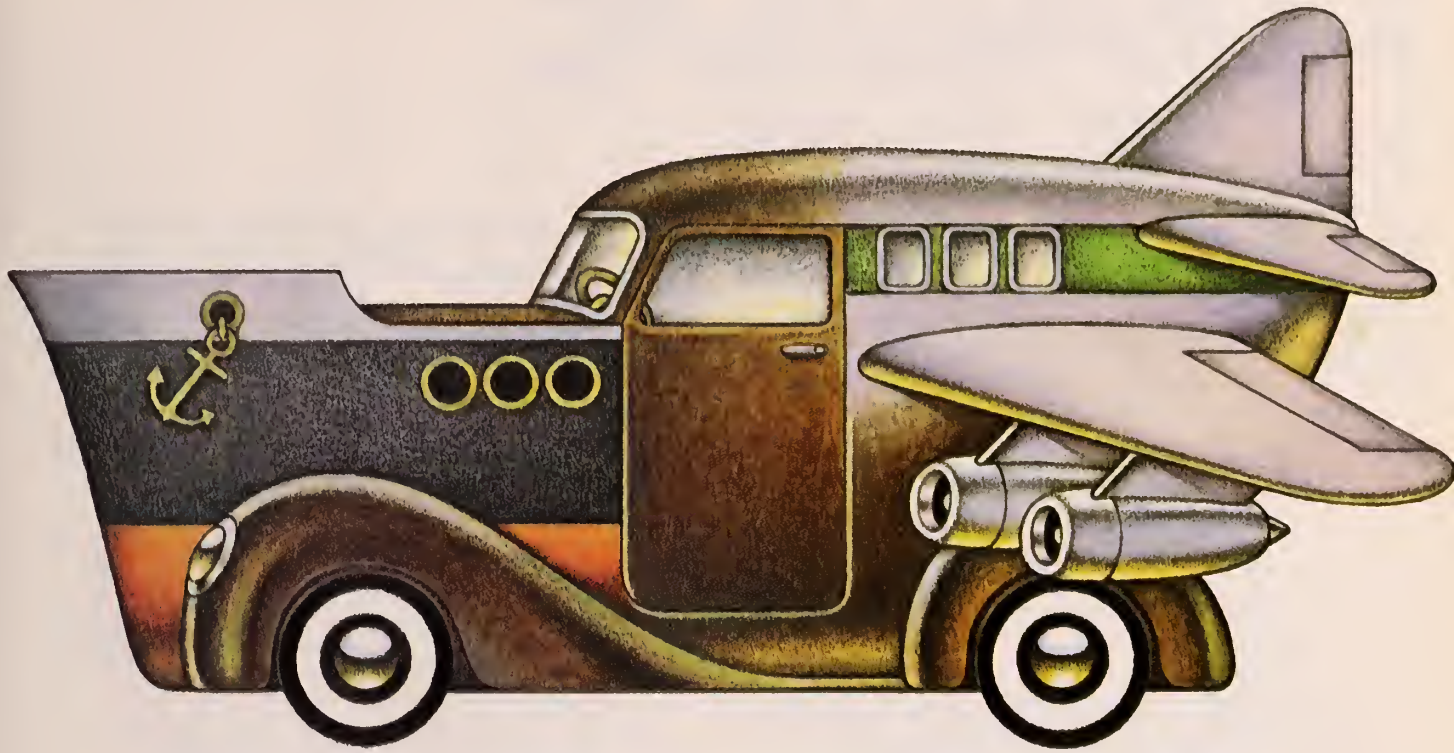
9. *Permit Introduction of Evidence Concerning Collateral Resources in a Malpractice Lawsuit*—this proposal was also introduced in both houses of the legislature, but neither the House or Senate acted on the bill and it died early in the session. This was by far the most controversial bill of the entire nine-point program since it has been the subject of debate for many years between the plaintiff and defendants bar. Although there was considerable agreement with many of our proposals by members of the legal profession, this bill was almost universally opposed by all attorneys even though they concede it would have the greatest effect on ultimately reducing the size of malpractice awards.

Other Legislative Activities—In addition to the nine-point legislative program noted above, your council, working with the association membership, was successful in blocking the enactment of bills which would have authorized optometrists to diagnose and use drugs and require health insurance policies to pay for chiropractic services on a mandatory basis in addition to allowing their participation in the Medicaid Program. The association was also successful in defeating several bills permitting substitution by a pharmacist of generic drugs for brand name products.

During this session of the legislature a bill was introduced in the House and Senate requiring all human blood used for transfusion purposes to be labeled as "donated" or "purchased." It would have also required that any physician who utilized "purchased" blood explain his reasons for so doing in the patient's record. There was considerable discussion of this proposal by the membership about the merits or demerits of this bill. The Council on Legislation at one of its meetings heard considerable testimony on this bill and there were members of MSMA who testified both for and against the proposal before a committee of the legislature. After considering the requirements of this proposal and the majority of the feelings of the membership the council elected to oppose it for this session. However, the council is of the opinion that the importance and impact of this bill is such that future policy concerning blood labeling should be determined by the House of Delegates after study and recommendation.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS, COUNCILS, AND BOARD OF TRUSTEES

This report of the Board of Trustees reviews the status of health legislation before the 1976 Regular Session of the Mississippi Legislature. We are happy to note passage of legislation dealing with the pro-



On land, sea, and in the air...

Up to 24 hours of effective control with a single dose...in nausea, vomiting and dizziness associated with motion sickness.

Dosage: 25 to 50 mg. 1 hour before travel.

Available on prescription only.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

CONTRAINDICATIONS. Administration of Antivert during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25 Chewable Tablets
(meclizine HCl) 25 mg.

for motion sickness

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*



Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Warning**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F CO., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

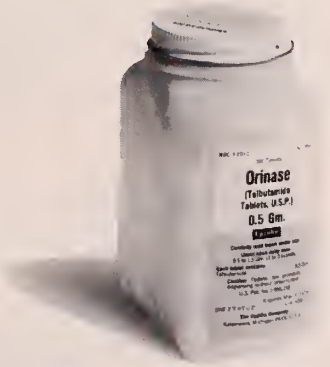
a new tablet design for



Orinase®

tolbutamide, Upjohn

0.5 Gm tablets



This new design will help pharmacists, physicians, nurses, and patients identify Orinase by name and manufacturer. The number on the tablet is for identification and is not related to tablet strength.

You may wish to advise your patients that this change is taking place.

J-5255-6

The Upjohn Company, Kalamazoo, Michigan 49001 **Upjohn**

©1976 The Upjohn Company

WHEN ANXIETY INTERFERES.

The cardiac patient and anxiety.



"The [cardiac] patient is anxious about minor symptoms, about the implications of his diagnosis, and about real or imagined limitations of function."*

The worst is over. The cardiac patient is out of the acute stage, out of the hospital, and well on his way to recovery. How quickly he comes back to near normal functioning may depend on his psychological as well as his physical rehabilitation.

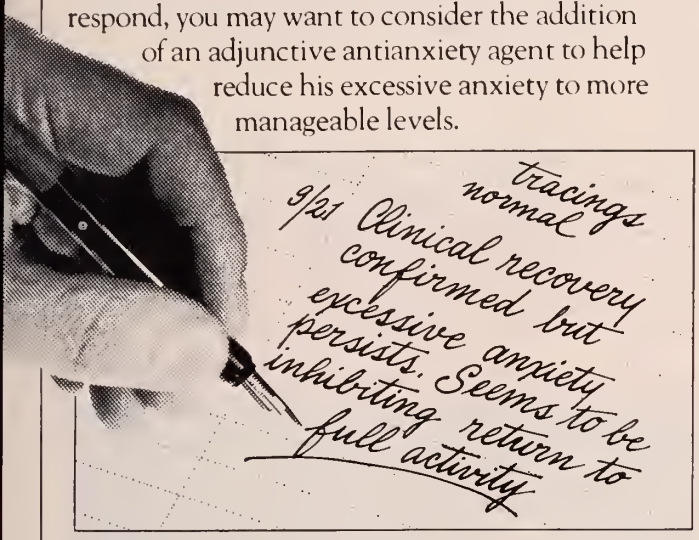
Clinical anxiety, for example, may be one reason for prolonged recuperation following cardiac healing. Yet anxiety can sometimes be beneficial in facilitating patient compliance.

The patient who is realistically concerned about resuming his precoronary functioning may be highly motivated to adhere to his rehabilitation regimen. However, the cardiac patient with *excessive* or unresolved anxiety may be so fearful of future heart failure that he refrains from your prescribed regimen. These excessively anxious cardiac patients eventually present the same clinical characteristics as patients deconditioned by bed rest.

Excessive anxiety can interfere with patient management

When excessive anxiety diminishes your

patient's ability to participate fully in his rehabilitation program, your counseling and reassurance are often sufficient. But when his anxiety is so great that it actually interferes with his ability to listen and respond, you may want to consider the addition of an adjunctive antianxiety agent to help reduce his excessive anxiety to more manageable levels.



Librium® (chlordiazepoxide HCl) an effective adjunct to your reassurance and counseling

Safety: Librium has a highly favorable benefits-to-risk ratio and a wide margin of safety. Because of its low incidence of side effects, it is regarded as one of the safest antianxiety agents available. And Librium does not adversely affect the cardiovascular system. See complete product information for warnings, precautions and adverse reactions.

Performance: Hundreds of clinical trials, thousands of published papers, and millions of patients comprise the record of performance for Librium.

Concomitant use: Of special significance in treating the cardiac patient already taking multiple agents is the fact that Librium is used concomitantly with most primary medications, such as cardiac glycosides, diuretics and antihypertensives.

*Zohman BL. *Geriatrics* 28:110-119, Feb 1973

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Adjunctive

LIBRIUM® Ⓒ

chlordiazepoxide HCl/Roche

5 mg, 10 mg, 25 mg capsules

THE ANXIETY-SPECIFIC

VISUAL FOCUS ON ACUTE GOUTY ARTHRITIS



Foot of patient with acute gouty arthritis as seen by conventional x-ray.



Scintiphotogram of same foot reflects inflammatory process.

The scintiphotograph on the right shows increased uptake of radiotechnetium polyphosphate in the metatarsophalangeal joint and the proximal interphalangeal joint of the great toe of a patient with acute gouty arthritis. This increased uptake probably results from increased vascularity in the affected areas.

For a more detailed description of scintiphotography, see "addendum" at right.

THERAPEUTIC FOCUS ON

CAPSULES, 25 mg and 50 mg

INDOCIN®

(INDOMETHACIN | MSD)

helps relieve pain and other symptoms of inflammation in acute gouty arthritis in selected patients

INDOCIN is a potent drug with anti-inflammatory, antipyretic, and analgesic properties. It should not be used in conditions other than those recommended. Although INDOCIN does not alter the progressive course of the underlying disease, in selected patients with acute gouty arthritis it has been found highly effective in relieving pain and in reducing fever, swelling, and tenderness.

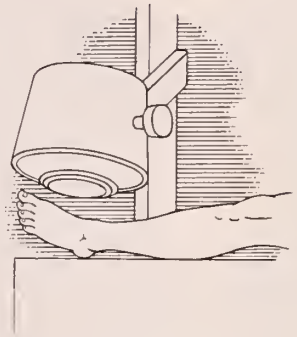
MSD
MERCK SHARP & DOHME

For a brief summary of prescribing information, please see following page.

addendum

MSD
MERCK SHARP & DOHME

Facts about Scintiphotography



In recent years a variety of radiopharmaceuticals have been employed to aid in the diagnosis of bone and joint disorders. The joint-imaging technique consists of injecting technetium polyphosphate intravenously, and imaging is performed with the scintillation camera two hours after the administration of the radionuclide. In general, for joint surveying, the shoulders, elbows, hands, wrists, knees, ankles, feet, and vertebral column are mapped. The entire scanning process takes approximately one hour. The criterion for a positive image is a higher concentration of radioactivity in a joint region than in adjacent nonarticular bone. In effect, each patient serves as his own control.

INDOCIN®
(INDOMETHACIN | MSD)



helps relieve pain
and other symptoms
of inflammation
in acute
gouty arthritis
in selected patients

IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended. The drug should not be prescribed for children because safe conditions for use have not been established.

Because of the high potency of the drug and the variability of its potential to cause adverse reactions, the following are strongly recommended: 1) the lowest possible effective dose for the individual patient should be prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg per day, without corresponding clinical benefits; 2) careful instructions to, and observations of, the individual patient are essential to the prevention of serious and irreversible, including fatal, adverse reactions, especially in the aging patient.

Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin or indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.

Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.

Central Nervous System Effects: INDOCIN may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS adverse reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

Drug Interactions: Although INDOCIN has not influenced the hypoprothrombinemia produced by anticoagulants, patients on anticoagulant therapy should be observed closely for alterations in prothrombin time. In patients receiving probenecid, plasma levels of indomethacin are likely to be increased and a lower total daily dose of INDOCIN may produce a therapeutic effect; increases in the dose of INDOCIN should be made cautiously and in small increments.

Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; rarely, intestinal ulceration has been associated with stenosis and obstruction; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis may persist after the cessation of the drug; nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.

Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.

Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.

Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura may occur rarely. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.

Hypersensitivity Reactions: Acute respiratory distress, a rapid fall in blood pressure resembling a shock-like state, angioedema, dyspnea, asthma, angiitis, pruritus, urticaria, skin rashes, purpura.

Ear Reactions: Hearing disturbances—deafness reported rarely; tinnitus.

Central Nervous System Reactions: Psychic disturbances including psychotic episodes, depersonalization, depression, and mental confusion; coma; convulsions; peripheral neuropathy; drowsiness; lightheadedness; dizziness; syncope; headache.

Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.

Dermatologic Reactions: Loss of hair, erythema nodosum.

Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.

Supplied: Capsules containing 25 mg indomethacin each, in single-unit packages of 100 and bottles of 100 and 1000; capsules containing 50 mg indomethacin each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

MSD MERCK SHARP & DOHME

fessional liability crisis. This legislation reduces the statute of limitation, grants an implied waiver of the medical privilege and authorizes establishment of a joint underwriting association to provide professional liability insurance should our present market disappear. We urge continued work by our members to gain passage of all professional liability legislation supported by the association based on actions of this House of Delegates at the October 1975 Special Session.

Your reference committee also considered the request of our Council on Legislation for guidance on various legislative proposals for labeling human blood. Other legislation dealing with this complex subject area was also before the 1976 Mississippi Legislature and will no doubt be reintroduced next year. Your reference committee believes that the association's Committee on Blood and Blood Banking should be reactivated and assigned the responsibility of studying this matter. The committee should have broad geographic and specialty representation and its recommendations should be referred to the Board of Trustees and Council on Legislation.

Your reference committee also urges continued opposition by all members of the association to legislation which would authorize optometrists to diagnose and to use drugs.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT B OF THE BOARD OF TRUSTEES

Background. Chapter I, Section 1, MSMA By-Laws provides the following with respect to membership eligibility: ". . . No physician shall be eligible for election to or continuation of membership who does not possess a currently effective federal narcotics stamp provided, however, that physicians in full time government service who need no registration to use, prescribe and dispense narcotic drugs and those who, by reason of type of practice, employment, inactivity, or retirement, neither prescribe nor dispense narcotics and who for that reason alone have not applied for registration shall be exempt from this requirement. . . ."

Under the "Disabled Physicians' Act" supported by the association and passed by the Mississippi legislature in 1975, a physician may voluntarily surrender his federal narcotics stamp and place himself in a rehabilitation program recommended by a committee of physicians named by the association. Chapter I, Section 1, MSMA By-Laws requires, however, that he lose his membership in the association in spite of his efforts for rehabilitation. The Board feels that this requirement is not constructive.

Recommendation. The Board of Trustees recommends the following amendment (italicized) to Chapter I, Section 1, MSMA By-Laws:

"Eligibility. Each component society of the Mississippi State Medical Association shall judge the qualifications of candidates for election to membership therein, which shall be restricted to those persons who hold the degree of Doctor of Medicine from an appropriately accredited source as defined by the American Medical Association, or in lieu thereof, a foreign degree in medicine which is an acceptable equivalent to the Board of Trustees and shall be a citizen of the United States. All candidates for any degree of membership other than associate or honorary must be legally licensed to practice medicine in Mississippi. Persons who obtained this degree prior to January 1, 1917, need not comply with this requirement but must be licensed to practice medicine in Mississippi or, if offering to practice in Mississippi must be eligible for license by reciprocity and be a member in good standing of a constituent (state) association of the American Medical Association. Membership in a component society, evidenced by the payment of dues for the current year, shall be a prerequisite to membership in the Association, except that a physician upon his initial application for membership in a component society of the Association shall be required to undergo a waiting period of ninety (90) consecutive days from the date he begins the practice of medicine in the geographical area of the component society before he may be elected to membership in the component society. No physician shall be eligible for membership who has been convicted of or who has plead guilty to either a felony or a violation of a state or federal narcotics law. The duly certified court record shall be prima facie evidence of pleas and convictions and cause automatic revocation of membership. No physician shall be eligible for election to or continuation of membership who does not possess a currently effective federal narcotics stamp, provided, however, that physicians in full time government service who need no registration to use, prescribe and dispense narcotic drugs and those who, by reason of type of practice, employment, inactivity or retirement, neither prescribe nor dispense narcotics and who for this reason alone have not applied for registration shall be exempt from this requirement. *Also, any member of the association who voluntarily surrenders his federal narcotics stamp and places himself in a rehabilitation program rec-*

ommended by that committee of physicians composed under the Mississippi Disabled Physician Act of 1975 shall be exempt from this requirement."

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

This report recommended amending our existing By-Law provision that requires possession of a currently effective federal narcotics stamp as a condition for membership in the association. This requirement, as stated by the Board, serves as an unnecessarily punitive impediment to any physician who wishes to *voluntarily* surrender his narcotics stamp and submit to a rehabilitation program for drug or alcohol abuse under terms of the Disabled Physicians Act of 1975.

Those members of the association who testified on this matter as well as the members of this council agree that it seems inconsistent to encourage voluntary surrender of a narcotics stamp and submission to rehabilitation under the Disabled Physicians Act while at the same time imposing a loss of membership in the association for so doing. Your reference committee, therefore, recommends that the following new language be added to Section 1, Chapter 1 of the MSMA By-Laws.

"Also, any member of the association who voluntarily surrenders his federal narcotics stamp and places himself in a rehabilitation program recommended by the examining committee of physicians under terms of the Mississippi Disabled Physicians Act of 1975 shall be exempt from this requirement."

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT C OF THE BOARD OF TRUSTEES

Scheduling of MSMA Annual Sessions—Section 2, Article V of the Constitution states that ". . . the time and place for holding the annual session shall be fixed by the House of Delegates . . ." and Section 1, Chapter II of the By-Laws states that ". . . the session shall . . . be held prior to the annual session of the American Medical Association. . . ."

Because of scheduling difficulties on a year-to-year basis, the House of Delegates approved a four-year advance schedule in 1967. Additionally, in 1970, the House of Delegates directed that future annual sessions be scheduled to avoid conflict with Mother's Day and with municipal elections. The former occurs on the second Sunday in May; primaries for the latter occur on the second Tuesday in May every four years.

Dates and Sites for the Annual Sessions—At the 106th Annual Session in 1974 the House of Delegates directed that the Association meet in Jackson in 1976 and thereafter meet on the gulf coast in odd numbered years and in Jackson in even numbered years. Based on this, the present annual session schedule is as follows:

Annual Session	*Place and Date*
109th	Biloxi, May 2- 5, 1977
110th	Jackson, May 1- 4, 1978
111th	Biloxi, May 7-10, 1979

108th Annual Session—The association has experienced innumerable heretofore uncommon difficulties in scheduling the 108th Annual Session in Jackson. These may be through the fault of no one but rather just the newness of the association scheduling a convention in Jackson. In any event, it is the Board's belief that the feasibility of scheduling future annual meetings in Jackson should be thoroughly discussed at this annual meeting.

Recommendation—Following requirements of the MSMA Constitution and By-Laws concerning scheduling of annual sessions of the Association and policies of the House of Delegates, the Board of Trustees recommends that the 112th Annual Session of the association be conducted May 5-8, 1980 at a site selected by the House of Delegates keeping in mind that only Jackson and Biloxi have adequate facilities for our meetings at this time.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS, COUNCILS, AND BOARD OF TRUSTEES

This report of the Board of Trustees advises on the association's policy to adopt a four-year advance schedule for annual meetings of the association and recommends that the May 5-8, 1980, meeting of the association be held at either Jackson or Biloxi, based on the wishes of the House of Delegates. At this time, the House has adopted the following schedule for annual sessions:

Annual Session	*Place and Date*
109th	Biloxi, May 2- 5, 1977
110th	Jackson, May 1- 4, 1978
111th	Biloxi, May 7-10, 1979

Your reference committee heard discussion both for and against holding annual sessions in Jackson. Your reference committee recommends that we continue to alternate meetings between Jackson and the Coast. Based on this recommendation, the 112th

Annual Session of the association will be held in Jackson on May 5-8, 1980.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT D OF THE BOARD OF TRUSTEES

Background. In "Supplemental Report E" to the House of Delegates at the 107th Annual Session, May 1975, the Board and Committee on Professional Liability Insurance reported a decline in the professional liability insurance market and an increasing cost for such coverage. At that time the only carrier writing new coverage in Mississippi announced implementation of a new "claims made" policy as an alternative to completely withdrawing from the market, and the carrier's rates for excess limits coverage increased by 70 per cent. In recognition of this and the fact that Mississippi was apparently becoming a victim of the national professional liability insurance crisis, the Board announced plans to study alternatives to the present professional liability insurance market.

Special Session of the House of Delegates. In October 1975, the president and Board called a special session of the House of Delegates to consider the professional liability insurance crisis. Proposed legislative solutions and alternatives to the present professional liability insurance market were presented for consideration by the House. More particularly with respect to the latter, the Board reported the growing trend toward establishment of "captive" professional liability coverage programs by state medical associations. Additionally, plans of the AMA to establish a reinsurance program for such captive programs were reported. Considering these and many other factors the most notable of which were that there was no competitive market for professional liability insurance coverage in Mississippi and no guarantee that the only carrier in Mississippi writing such coverage would continue to do so, the Board recommended:

(a) That a nonprofit physician membership corporation be chartered under the laws of Mississippi;

(b) That contributions to the corporation be tax-exempt to the same extent as present liability insurance premiums;

(c) That reinsurance of the corporation's risks and excess limits coverage be available;

(d) That a minimum of 750-1,000 physicians express their intent to become members of the corporation through investment of an initial membership fee to provide a pool of approximately $700,000.

The above recommendations were adopted by the House of Delegates.

Status of Corporation. Based on the above the Board wishes to report incorporation of the "Mississippi Medical Fraternal and Educational Society." Application for tax-exempt status for the corporation is being made. Within recent months the American Medical Association has established the American Medical Assurance Company as a reinsurance facility. The American Medical Association will conduct a national conference on physician owned insurance companies in Chicago on May 21, 1976, and representatives of MSMA will be present.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS, COUNCILS, AND BOARD OF TRUSTEES

This report gives the status of formation of a nonprofit physician membership corporation to provide professional liability coverage for Mississippi physicians in accordance with actions of the House of Delegates at the October 1975 Special Session. Specifically, the Board reports incorporation but not activation of the "Mississippi Medical Fraternal and Educational Society."

Your reference committee accepts the report for information and notes that the Board will report further on this matter as progress is made.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT E OF THE BOARD OF TRUSTEES

Background. At the present time there are nine scientific sections of the association meeting during the annual session. They are the Sections on Medicine, Surgery, Preventive Medicine, Ob-Gyn, EENT, Pediatrics, Family Practice, Anesthesiology and Radiology. The sections are enumerated in Chapter IV, Section 1, MSMA By-Laws. Two sections have been added within the past two years and the Board understands that other specialty groups will be seeking sections at this annual session.

The Board wishes to apprise the House of Delegates of this situation and its effect on the format and cost of the annual session. With respect to the former, the House should be aware that several years ago it expressed a desire to see the scientific sections offer programs of general medical interest and, to the extent possible, not meet concurrently. The House also called on the section officers to seek scientific speakers on general topics from the several specialties not represented in the scientific sections.

The reason behind this expression was that the association did not have a sufficiently large and broadly specialized membership to provide attendance at either several scientific meetings running concurrently or at highly specialized meetings. This was borne out by the attendance at some of the scientific sections when an outstanding out-of-state speaker would present a paper to an audience of four to six MSMA members.

At this time the annual session officially opens on Monday. The House of Delegates and the reference committees meet on that day and the closing session of the House is conducted on Thursday morning to conclude the meeting. Tuesday and Wednesday are, therefore, available for meetings of the scientific sections unless they meet on Sunday. This does not provide much time for nonconflicting meetings of the scientific sections and the situation is made more acute with the addition of each new section. Further, it should be noted that most specialty societies representative of the scientific sections now meet in conjunction with the sections.

With respect to the cost of the scientific sections, the association at this time, by custom, pays the travel expenses of at least two out-of-state speakers for each of the scientific sections. The addition of each new section commits the association to further expenses in this regard.

Recommendation. The Board of Trustees recommends that the House of Delegates consider present policies for establishing new scientific sections. The question appears to be whether a section will be established for each specialty group represented in the state and if not then where is the line to be drawn? One criterion for the latter might be that no further new sections will be established unless there are at least 75 MSMA members in the specialty of the proposed scientific section. Further, the Board recommends that the association henceforth pay the expenses of one out-of-state speaker for each scientific section and encourage the particular specialty society which is represented by each section to pay the expenses for an additional out-of-state speaker, if such speaker is desired.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS, COUNCILS, AND BOARD OF TRUSTEES

This report reviews the increase in scientific sections of the association. It notes that two sections have been added within the past two years for a total of nine sections at this time with more being proposed.

The report recommends that the House of Delegates review present policies for establishing sections. Also, that henceforth the association pay the expenses of one out-of-state speaker for each section instead of the present authorized two speakers.

Your reference committee heard discussion in favor of not limiting the number of authorized scientific sections. However, we believe it was recognized by all that the association should conduct a scientific program of broad interest as part of the annual session while encouraging as many separate specialty meetings as desired. We, therefore, recommend that the Council on Scientific Assembly which is composed of the several scientific sections' officers, plan a general scientific program for the membership. Each section should be authorized to place one out-of-state speaker on the program whose expenses would be paid by the association. The scientific sections may meet in conjunction with their respective specialty societies if desired.

After discussion of the recommendation, Dr. W. Moncure Dabney of Crystal Springs moved to delete that portion of the report which stated: "Each section should be authorized to place one out-of-state speaker on the program whose expenses would be paid by the association," leaving this decision to the Council on Scientific Assembly.

The motion was seconded by Dr. Stanley A. Hill of Corinth and adopted.

The report of the reference committee was adopted as amended.

REPORT OF THE SECRETARY-TREASURER

Dr. James P. Spell: Duties and Responsibilities—As an elected general officer of the association, your Secretary-Treasurer is charged with such duties as ordinarily devolve upon the secretary of a corporation by law, custom, and usage. Additionally, he is the constitutional designee to serve as chairman of the Council on Scientific Assembly and member *ex officio* of all councils and committees.

Membership—Total membership as of December 31, 1975, was as follows:

1,429 Paid Active Members
94 Exempt Members

This is a total of 1,523 MSMA for 1975. As of December 31, 1974, we had 1,410 paid active members. As of April 6, 1976, our current year's membership was:

1,338 Paid Active Members
102 Exempt Members

This is a total of 1,440 for 1976. Additional payments of dues have been made since preparation of these data.

Fiscal Reporting—In accordance with usual practice, your Secretary-Treasurer submits a condensed statement of your association's financial condition. The Council on Budget and Finance prepared the budget for 1976 which was approved by the Board of Trustees in accordance with association policy and is available for inspection by any member.

MISSISSIPPI STATE MEDICAL ASSOCIATION
Condensed Statement of Financial Condition
December 31, 1975

ASSETS

Current Assets		
General Fund		
Cash on Deposit	$324,157.23	
Accounts Receivable—Journal	3,806.99	
Accounts Receivable—CHAMPUS	11,176.98	
Other Current Receivables	41,334.82	
Inventory—Insurance Forms	2,474.10	
Prepaid Expenses	6,453.90	
Total Current Assets		$389,404.02
Fixed Assets		
Building, Computer, Office Furniture and Equipment, Less Depreciation	$204,788.71	
Land (at cost)	14,242.38	
Total Fixed Assets		$219,031.09
Deferred Expenses		
Deferred CHAMPUS Expenses	$ 4,622.96	
Deferred Computer Installation Cost	778.05	
Total Deferred Expenses		$ 5,401.01
Other Assets		
Refundable Deposits	$ 25.00	
		$ 25.00
Total Assets		$613,861.12

LIABILITIES AND NET WORTH

Current Liabilities		
Accrued Expenses	$ 8,089.07	
Accounts Payable		
Local Society Dues	25,763.00	
Auxiliary Dues	4,245.00	
Dues & ERF	181,430.00	
AMPAC & MPAC	17,820.00	
Government—CHAMPUS	1,992.55	
Government—Emcro	11,126.10	
Legal Fund Reserve	6,427.57	
Malpractice Fund Reserve	1,000.00	
Mortgage Payable		
Current Portion—Note C	7,120.00	
Lease Purchase Payable		
Current Portion—Note E	12,814.20	
Accrued & Withheld Taxes	2,434.87	
Other Current Liabilities	247.84	
Total Current Liabilities		$280,510.20
Long-Term Liabilities		
Mortgage Payable—Deposit Guaranty National Bank—Note C	$ 48,060.00	
Lease Purchase Payable—Note E	25,628.40	
		$ 73,688.40
Deferred Income		$117,037.35
Net Worth		
Unappropriated Net Worth December 31, 1974	$130,520.24	
Net Income for Year Ended December 31, 1975	12,104.93	
Net Worth, December 31, 1975		$142,625.17
Total Liabilities And Net Worth		$613,861.12

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS, COUNCILS AND BOARD OF TRUSTEES

Your reference committee considered the report of our secretary-treasurer. We concur with the report and note the normal financial and membership status of the association.

The report of the reference committee was adopted.

REPORT OF THE EXECUTIVE SECRETARY

Mr. Charles L. Mathews, Executive Secretary: The office of the executive secretary staffs and administers the activities of the association under the direction and supervision of the Board of Trustees. This report is intended as an overview of your administrative staff and association programs and activities.

Programs and Activities—As noted in the various reports before you at this annual session the staff has been involved in an increasing number of activities during the 1975-76 association year. There have been the professional liability insurance crisis and a "Special Session" of the House of Delegates in this regard, increased peer review activities, oversight of important new health legislation and regulations and new committee responsibilities, to mention a few. These have occurred along with the ongoing operations of your Journal MSMA, councils, committees and regular membership services.

In a context of increasing costs we have sought economy in association operations during the year without sacrificing programs and services to the membership. We are happy to note that the association ended 1975 with a modest improvement in its financial position over 1974.

Socioeconomic aspects of health care have become a growing concern to the association. The efforts of the staff under the direction of the Board, councils and committees of the association are increasingly involved in this area of public and professional concern. We will continue to strengthen staffing capability and resources in this subject area.

We continue to try to improve communication with the membership on matters of concern to the profession. In this connection we are carrying more

Mississippi medical news in the JOURNAL MSMA and the staff is attending many local society meetings for the purpose of discussing MSMA programs and activities. Additionally, the "Blue Sheet" continues to serve as an effective method for communicating with the membership.

Staff—There are at present 27 employees at your MSMA office. Nine of these employees have duties with association programs such as the JOURNAL MSMA, membership, data processing, internal management and council and committee work. All nine positions have been authorized since 1970. All other staff positions are with the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). CHAMPUS processed over $2 million in claims during 1975.

Your MSMA office building is at capacity with present staff and programs.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS, COUNCILS AND BOARD OF TRUSTEES

Your reference committee received the report of our executive secretary concerning administrative and staff functions during the 1975-76 association year. We commend the staff for their work in our behalf.

The report of the reference committee was adopted.

RESOLUTION NO. 1, IN MEMORIAM

Dr. James P. Spell:

WHEREAS, There are absent from among our numbers 29 members who have been called by Divine Providence since the 107th Annual Session; and

WHEREAS, Although we are grieved by the passing of these beloved colleagues and friends, we are inspired by their lives of service and professional attainment; and

WHEREAS, This expression of our grief, deep affection, and respect should be recorded permanently among official records of the Mississippi State Medical Association, now therefore, be it

Resolved, That this House of Delegates does mourn the passing of the following esteemed colleagues:

Hackett Bennett, Meridian, August 19, 1975
Ira B. Bright, Greenwood, January 21, 1976
Linfield Costley, Meadville, April 22, 1975
James W. Cox, Columbus, April 24, 1975
Ottis B. Crocker, Bruce, June 17, 1975
J. P. Culpepper, Jr., Hattiesburg, August 4, 1975
John R. Durfey, Jr., Canton, February 11, 1976
Joseph S. Edmondson, Vardaman, May 28, 1975
Richard H. Fenstermacher, Vicksburg, January 7, 1976
Fred Geisenberger, Natchez, July 20, 1975
James D. Hutchins, Prentiss, May 17, 1975
Wiley D. Lewis, Meridian, June 19, 1975
Thomas J. Marland, Jackson, November 17, 1975
Joseph G. McKinnon, Hattiesburg, November 30, 1975
L. B. Morris, Macon, November 21, 1975
William W. Nobles, Tunica, July 3, 1975
William E. O'Mara, Carthage, January 15, 1976
James A. Overby, Jackson, March 24, 1976
Joseph G. Peeler, Sr., Shaw, March 7, 1976
Robert H. Peeples, Greenville, April 21, 1975
Robert H. Pegram, Jr., Tupelo, February 21, 1976
C. W. Rayburn, Pontotoc, August 25, 1975
Theodore H. Rayburn, Pontotoc, March 4, 1976
Henry C. Ricks, Sr., Jackson, July 4, 1975
T. Erskine Ross, Jr., Hattiesburg, June 8, 1975
William M. Suttle, Jackson, October 21, 1975
Frank K. Tatum, San Benito, Texas, October 30, 1975
G. G. Townsend, Forest, February 7, 1976
Walter Dean Vick, Grenada, March 21, 1976

ACTION OF THE HOUSE OF DELEGATES

Without objection, Resolution No. 1 was acted upon without referral and adopted by the House of Delegates with all present standing in silent tribute.

RESOLUTION NO. 2, PHYSICIANS' PROFESSIONAL LIABILITY INSURANCE

Dr. Charles N. Floyd:

WHEREAS, The increasing cost of physicians' professional liability insurance is a matter of great concern to both the public and the medical profession; and

WHEREAS 42 claims were filed against physician insureds of the major carrier in Mississippi during the period 1961-1973; and

WHEREAS, The number of claims rose to 60 in 1974 alone; and

WHEREAS, Only about 25 per cent of professional liability claims against physicians result in a finding for the plaintiff; and

WHEREAS, This increase in professional liability claims and the low number of decisions for plaintiffs indicate that perhaps suits are being filed maliciously and/or without proper legal consideration; now therefore be it

Resolved, That in the interest of the public and

the medical profession all members of the Mississippi State Medical Association voluntarily contribute to a legal fund established by the association to seek legal redress against any plaintiff and/or attorney filing a malpractice suit against a member of the association which appears to have no legal foundation and/or to be filed maliciously.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS, COUNCILS AND BOARD OF TRUSTEES

This resolution was introduced by Dr. Charles N. Floyd, council member, on behalf of the Coast Counties Medical Society. This resolution provides:

"Resolved, That in the interest of the public and the medical profession all members of the Mississippi State Medical Association voluntarily contribute to a legal fund established by the association to seek legal redress against any plaintiff and/or attorney filing a malpractice suit against a member of the association which appears to have no legal foundation and/or to be filed maliciously."

Your reference committee believes that the medical and legal professions should work together to resolve the professional liability crisis. We are happy to note reactivation of the MSMA/Mississippi Bar Association Liaison Committee. The committee met on numerous occasions during the past year to discuss the professional liability crisis. We also note that the Bar Association has grievance (or peer review) committees similar to ours where matters such as those addressed by Resolution No. 2 may be brought for consideration and appropriate action. In light of the aforementioned facts your reference committee recommends that Resolution No. 2 be not adopted.

In discussion, Drs. J. Dan Mitchell of Jackson, Charles N. Floyd of Gulfport, A. K. Martinolich of Bay St. Louis and Ray H. Stewart of Gulfport spoke against the reference committee report and in favor of Resolution No. 2. Dr. Moncure Dabney of Crystal Springs spoke in favor of the reference committee report. The speaker then called for a standing vote and the report of the reference committee was adopted by a vote of 53 ayes and 45 nays.

The report of the reference committee was adopted.

RESOLUTION NO. 3, MSMA APPROVAL AND SUPPORT OF THE COMMITTEE ON BLOOD BANKING OF MISSISSIPPI STATE ASSOCIATION OF PATHOLOGISTS

Dr. Karl W. Hatten:

WHEREAS, Human blood donors and blood transfusions are a vital and important aspect of medical practice; and

WHEREAS, The Mississippi Association of Pathologists now has a Committee on Blood Banking; and

WHEREAS, The director of the Mississippi Regional Blood Center is also on this committee; and

WHEREAS, Some confusion and misunderstanding presently exists in Mississippi concerning various blood programs; and

WHEREAS, Such confusion and strife is detrimental to donor recruitment and public opinion; now therefore be it

Resolved, That this Committee on Blood Banking of the Mississippi Association of Pathologists be approved and endorsed by the Mississippi State Medical Association; and be it further

Resolved, That the Mississippi State Medical Association receive a formal report from this committee yearly, or more often if needed; and be it further

Resolved, That the Mississippi State Medical Association lend its full efforts to assist the work of this committee when and if such requests are made.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS, COUNCILS AND BOARD OF TRUSTEES

This resolution was introduced by Dr. Karl W. Hatten, delegate, on behalf of the West Mississippi Medical Society. This resolution provides:

"Resolved, That this Committee on Blood Banking of the Mississippi Association of Pathologists be approved and endorsed by the Mississippi State Medical Association; and be it further

"Resolved, That the Mississippi State Medical Association receive a formal report from this committee yearly, or more often if needed; and be it further

"Resolved, That the Mississippi State Medical Association lend its full efforts to assist the work of this committee when and if such requests are made."

Your reference committee believes that the association should conduct study and activity in the area addressed by this resolution. We note that the House of Delegates presently has authorized a constitutional Committee on Blood and Blood Banking. We urge activation of the committee with both geographic and specialty representation. We recommend that Resolution No. 3 be not adopted.

The report of the reference committee was adopted.

RESOLUTION NO. 4, ESTABLISH A SECTION ON PSYCHIATRY

Dr. Ellis Moffitt:

WHEREAS, The American Medical Association has for some time recognized a section on psychiatry within its organization; and

WHEREAS, The Mississippi Psychiatric Association is a recognized branch of the American Psychiatric Association, and all its members are in good standing with the American Psychiatric Association; and

WHEREAS, Members of the Mississippi Psychiatric Association have for some time been very active in affairs of the Mississippi State Medical Association; and

WHEREAS, The Mississippi Psychiatric Association has previously expressed its desire to develop a scientific section of the Mississippi State Medical Association and last year did meet during the annual May meeting of the Mississippi State Medical Association; now therefore be it

Resolved, That the Mississippi State Medical Association recognize the specialty of psychiatry as a section within the association under requirements of Chapter IV, MSMA By-Laws.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

Your reference committee considered Resolution No. 4 introduced by Dr. Ellis Moffitt, delegate from Hinds County. This resolution provides:

"*Resolved,* That the Mississippi State Medical Association recognize the specialty of psychiatry as a section within the association under requirement of Chapter IV, MSMA By-Laws."

This was one of three resolutions introduced in the House of Delegates requesting recognition of a specialty as a scientific section under the MSMA By-Laws. Your reference committee recognizes that the continued addition of new specialty sections each year creates a financial and logistical burden on the Council on Scientific Assembly in preparing its annual scientific program. However, it is hoped that any problems attendant to increasing sections will be addressed by the Reference Committee on Reports of Officers, Councils and Board of Trustees in its consideration of Report E of the Board of Trustees. In the meantime, it is the feeling of your reference committee that the only important and equitable condition to acceptance of any new specialty section should be an acknowledged desire to improve the quality of medical education in our scientific program. For these reasons your reference committee recommends adoption of Resolution No. 4.

The report of the reference committee was adopted.

RESOLUTION NO. 5, ESTABLISH SECTION ON DERMATOLOGY

Dr. Ellis Moffitt:

WHEREAS, The American Medical Association has for some time recognized a section on dermatology within its organization; and

WHEREAS, The members of the Mississippi Dermatological Society are members of the American Academy of Dermatology; and

WHEREAS, The Mississippi Dermatological Society has held its annual meeting on the Sunday preceding the Mississippi State Medical Association's annual meeting at the site of the MSMA session; and

WHEREAS, The dermatologists of Mississippi as represented by the Mississippi Dermatological Society desire to be recognized and accepted as a section in the scientific assembly; now therefore be it

Resolved, That the Mississippi State Medical Association recognize the specialty of dermatology as a section within the association under requirements of Chapter IV, MSMA By-Laws.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

Your reference committee considered Resolution No. 5 introduced by Dr. Ellis Moffitt, delegate from Hinds County. This resolution provides:

"*Resolved,* That the Mississippi State Medical Association recognize the specialty of dermatology as a section within the association under requirements of Chapter IV, MSMA By-Laws."

For the reasons stated above your reference committee is in accord with this amendment and recommends the adoption of Resolution No. 5.

The report of the reference committee was adopted.

RESOLUTION NO. 6, SWINE FLU VACCINATION PROGRAM

Dr. Ellis Moffitt:

WHEREAS, During 1976, person to person transmission of swine influenza A virus (A/New Jersey/11/76) was demonstrated at Fort Dix, New Jersey; and

WHEREAS, It is not known if or when this strain of influenza will cause a major epidemic but historical and scientific evidence suggest it may occur; and

WHEREAS, The Center for Disease Control (DHEW) in concurrence with a panel of influenza experts, has recommended that *all persons* in the United States be vaccinated against this strain of influenza virus; a decision with which the Mississippi State Board of Health agrees; and

WHEREAS, The Center for Disease Control proposes to secure the necessary vaccine, distribute it

free to all state health departments and aid in administering the vaccine through support of the state's immunization project grant; and

WHEREAS, Two vaccines, directed at separate target groups, with different distribution times but with vaccination schedules to be completed, if at all possible by December, will not be available in sufficient quantity to vaccinate the full population; and

WHEREAS, The magnitude of the task requires the continued close cooperation and maximal support between private physicians and the Mississippi State Board of Health.

Now, Therefore, Be It Resolved, That the Mississippi State Medical Association pledges again its unqualified support to the Mississippi State Board of Health in organizing and conducting the vaccination program for the protection of the people of the state against the possible outbreak of influenza during the 1976-77 season and calls upon the membership to:

1. participate in local, mass vaccination clinics;
2. share in the health department telephone answering service to respond to queries about vaccine side effects;
3. participate in administration of vaccine to certain groups for whom they have previously assumed responsibility (nursing homes, businesses, industries, etc.);
4. administer vaccine (if available and if necessary) to persons missed by the initial campaigns, without charge for the vaccine itself and in accord with federal guidelines for accountability and informed consent; and
5. assist in whatever other ways may from time to time appear to most effectively aid in accomplishing the goals of this program.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS, COUNCILS AND BOARD OF TRUSTEES

This resolution was introduced by Dr. Ellis Moffitt, delegate from Hinds County. The resolution provides:

"Resolved, That the Mississippi State Medical Association pledges again its unqualified support to the Mississippi State Board of Health in organizing and conducting the vaccination program for the protection of the people of the state against the possible outbreak of influenza during the 1976-77 season and calls upon the membership to:

"1. participate in local, mass vaccination clinics;

"2. share in the health department telephone answering service to respond to queries about vaccine side effects;

"3. participate in administration of vaccine to certain groups for whom they have previously assumed responsibility (nursing homes, businesses, industries, etc.);

"4. administer vaccine (if available and if necessary) to persons missed by the initial campaigns, without charge for the vaccine itself and in accord with federal guidelines for accountability and informed consent; and

"5. assist in whatever other ways may from time to time appear to most effectively aid in accomplishing the goals of this program."

Your reference committee had the benefit of much discussion in regard to this resolution. We particularly thank the public health officials who appeared at our committee to discuss the proposed swine flu vaccination program. Your reference committee recommends adoption of the following substitute resolution:

"Resolved, That the Mississippi State Medical Association pledges again its unqualified support to the Mississippi State Board of Health in organizing and conducting the vaccination program for the protection of the people of the state against the possible outbreak of influenza during the 1976-77 season and calls upon the membership to:

"1. participate in local, mass vaccination clinics;

"2. administer vaccine (if available and if necessary) to persons missed by the initial campaigns, without charge for the vaccine itself and in accord with federal guidelines for accountability and informed consent; and

"3. assist in whatever other ways may from time to time appear to most effectively aid in accomplishing the goals of this program."

After discussion of the recommendation Dr. Calvin T. Hull of Jackson moved that an item 4 be added stating that "the *swine flu vaccine not be given to pregnant women until further study be made as to its safety.*" The motion was seconded by Dr. W. H. Preston, Jr., of Booneville and adopted.

The report of the reference committee was adopted as amended.

RESOLUTION NO. 7, HEALTH SYSTEM AGENCY, INC.

Dr. Robert F. Carter:

WHEREAS, The notice given by Health Systems Agency, Inc., concerning meetings to elect their Subarea Advisory Councils was inadequate;

WHEREAS, The meeting to elect the Sub-area Advisory Council in the Southern District occurred during the MSMA Annual Session when an adequate number of physicians were unable to attend;

WHEREAS, The Southern District is disenfranchised by virtue of the fact that it has 25 per cent of the physicians and consumers, all of whom are represented in one district;

WHEREAS, The telephone number of the Health Systems Agency, Inc. is the telephone number of the Mississippi Optometric Association;

Now Therefore Be It Resolved, That the Mississippi State Medical Association protest the election of members of the Health Systems Agency, Inc. Sub-area Advisory Councils since these councils will ultimately decide who serves on the Board of Directors of Health Systems Agency, Inc.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS, COUNCILS, AND BOARD OF TRUSTEES

This resolution was introduced by Dr. Robert F. Carter, delegate, Coast Counties Medical Society. The resolution provides:

"Resolved, That the Mississippi State Medical Association protest the election of members of the Health Systems Agency, Inc. Sub-area Advisory Councils since these councils will ultimately decide who serves on the Board of Directors of Health Systems Agency, Inc."

Your reference committee heard much discussion regarding Public Law 93-641, the National Health Planning and Resources Development Act and its present manner and method of implementation in Mississippi. We concur with the intent of Resolution No. 7. We recommend, however, the following substitute resolution:

"Resolved, That the Mississippi State Medical Association does strongly protest the discriminatory and arbitrary manner in which the Mississippi Health Systems Agency, Inc. is presently attempting to implement Public Law 93-641; and

"Resolved, That the Mississippi State Medical Association does urge that if regional areas are to be established in Mississippi as proposed by the Mississippi Health Systems Agency, Inc., they should bear some relationship to health service areas, and

Resolved, That the Mississippi State Medical Association does urge that if subarea councils are to be established in Mississippi as proposed by the Mississippi Health Systems Agency, Inc., they should be elected by local residents only who appear at meetings conducted at reasonable times and places of their own free will; and

"Resolved, That the Mississippi State Medical Association does strongly protest the manner in which health provider positions have been elected on various councils proposed by the Mississippi Health Systems Agency, Inc.; and

"Resolved, That copies of this resolution be furnished to all concerned health organizations in Mississippi; and

"Resolved, That copies of the above resolution be furnished to the Secretary of HEW, the Mississippi Congressional Delegation, Governor of Mississippi and members of the Mississippi Legislature."

In discussion, Dr. G. Swink Hicks of Natchez requested unanimous consent for a member of the association, Dr. D. T. Amacker of Natchez, to address the House for not more than five minutes. There was objection to Dr. Hicks' request and Dr. Hicks stated that he would read an amendment to the reference committee report authored by Dr. Amacker and move its adoption. Dr. Hicks then presented the following as an addition to the reference committee report:

"Resolved, That the MSMA House of Delegates direct the Board of Trustees and/or those designated by the board to:

"1. Arrange a meeting with the Governor and the Office of Comprehensive Health Planning forthwith to propose each person designated to serve on the Board of Comprehensive Health Planning or its designated group for the purpose of having state medical association input in the future health planning of this state, and

"2. Request the job of training and orientation of persons designated for this job."

The motion was seconded by Dr. Sidney Graves of Natchez and after discussion was adopted.

Dr. Charles R. Jenkins then moved the following additional amendment to the amendment just adopted:

"3. Request the Governor to designate three to six health system areas for Mississippi."

The motion was seconded by Drs. Joe M. Ross, Jr. of Vicksburg and J. Dan Mitchell of Jackson and after discussion was adopted.

Drs. Howard D. Clark of Morton and John R. Lovelace of Batesville spoke in opposition to the recommendation of the reference committee. Dr. Lovelace moved that the report of the reference committee be tabled and the motion was seconded by Dr. John G. Egger of Drew. The speaker called for a vote on the motion and the motion was defeated by a vote of 19 ayes and 43 nays.

Discussion then continued on the report of the

reference eommittee as amended. Dr. G. Leroy Howell of Starkville moved that the Board of Trustees be instrueted to form a nonprofit eorporation that eould apply for designation and funding as the Health Systems Ageney for Mississippi. The motion was seeonded by Dr. William C. Gates, Jr. of Columbus and after diseussion and eomment that sueh an association sponsored organization would not be eligible for funding as a Health Systems Ageney, the speaker ealled for a vote on the motion and it was defeated.

Discussion then eontinued on the report of the referenee eommittee as amended. Dr. Samuel B. Johnson of Jaekson moved to add the following additional resolve to the referenee eommittee report as amended:

"Resolved, That the House of Delegates authorize and direet the Board of Trustees to seek legal counsel regarding whether sufficient grounds may exist to bring a legal aetion regarding the manner of implementation of Publie Law 93-641 in Mississippi and proeeed as seems appropriate and desirable."

The motion was seeonded by Dr. John G. Egger of Drew and after discussion the speaker called for a vote and the motion was adopted.

At this time the speaker stated the report of the referenee eommittee before the House as amended to read as follows:

Resolved, That the Mississippi State Medieal Assoeiation does strongly protest the diseriminatory and arbitrary manner in which the Mississippi Health Systems Ageney, Ine. is presently attempting to implement Publie Law 93-641; and

Resolved, That the Mississippi State Medieal Assoeiation does urge that if regional areas are to be established in Mississippi as proposed by the Mississippi Health Systems Ageney, Ine., they should bear some relationship to health serviee areas; and

Resolved, That the Mississippi State Medieal Association does urge that if sub-area eouneils are to be established in Mississippi as proposed by the Mississippi Health Systems Agency, Ine., they should be eleeted by loeal residents only who appear at meetings conducted at reasonable times and places of their own free will; and

Resolved, That the Mississippi State Medieal Assoeiation does strongly protest the manner in whieh health provider positions have been eleeted on various eouneils proposed by the Mississippi Health Systems Agency, Ine.; and

Resolved, That the eopies of this resolution be furnished to all eoneerned health organizations in Mississippi; and

Resolved, That eopies of the above resolution be furnished to the Seeretary of HEW, the Mississippi Congressional Delegation, Governor of Mississippi and members of the Mississippi Legislature; and

Resolved, That the MSMA House of Delegates direet the Board of Trustees and/or those designated by the Board to: (1) arrange a meeting with the Governor and the Offiee on Comprehensive Health Planning forthwith to propose eaeh person designated to serve on the Board of Comprehensive Health Planning or its designated group for the purpose of having State Medieal Assoeiation input in the future health planning of this state, and (2) request the job of training and orientation of those persons designated for this job, and (3) request the Governor to designate three to six health systems areas for Mississippi; and

Resolved, That the House of Delegates authorize and direet the Board of Trustees to seek legal eounsel regarding whether suffieient grounds may exist to bring a legal aetion regarding the manner of implementing PL 93-641 in Mississippi, and proeeed as seems appropriate and desirable.

The speaker ealled for diseussion of the referenee eommittee report and there being none, a vote was ealled and the report of the reference eommittee as amended was adopted.

RESOLUTION NO. 8, MSMA SUPPORT OF THE UNIVERSITY MEDICAL CENTER THROUGH THE COUNCIL ON LEGISLATION

Dr. David R. Steckler:

WHEREAS, The University of Mississippi Medical Center is the only institution in Mississippi for the graduate and postgraduate training of physieians, and

WHEREAS, Other programs to train health professionals are also eondueted at the University Medical Center, and

WHEREAS, The betterment of health eare for our patients is the prime eoneern of all physieians; now therefore be it

Resolved, That the Mississippi State Medieal Assoeiation, through its effeetive Council on Legislation, support the needs of the University of Mississippi Medieal Center in working together to improve health eare in Mississippi.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS, COUNCILS AND BOARD OF TRUSTEES

This resolution was introdueed by Dr. David R. Steekler, delegate, Adams County. The resolution provides:

"Resolved, That the Mississippi State Medical

Association, through its effective Council on Legislation, support the needs of the University of Mississippi Medical Center in working together to improve health care in Mississippi."

Your reference committee concurs with the intent of this resolution. We believe, however, that our direct involvement as an association in supporting our University Medical Center should be at the request of the Vice Chancellor for the University Medical Center. We, therefore, recommend the following substitute resolution:

"*Resolved,* That at the request of the Vice Chancellor of our University of Mississippi Medical Center, this association, through its Council on Legislation, support the needs of the medical center in working to improve health care in Mississippi."

The report of the reference committee was adopted.

RESOLUTION NO. 9, ESTABLISH SECTION ON PATHOLOGY

Dr. David R. Steckler:

WHEREAS, The American Medical Association has for many years recognized a Section on Pathology within its organization; and

WHEREAS, The members of Mississippi Association of Pathologists are members of the American College of Pathology; and

WHEREAS, The Mississippi Association of Pathologists has held its annual meeting on the Sunday preceding and on the Monday of the Mississippi State Medical Association's annual meeting at the site of the MSMA session; and

WHEREAS, The pathologists of Mississippi as represented by the Mississippi Association of Pathologists desire to be recognized and accepted as a section in the scientific assembly; now therefore be it

Resolved, That the Mississippi State Medical Association recognize the specialty of pathology as a section within the association under requirements of Chapter IV, MSMA By-Laws.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

Your reference committee considered Resolution No. 9 introduced by Dr. David Steckler, delegate from Adams County. This resolution provides:

"*Resolved,* That the Mississippi State Medical Association recognize the specialty of pathology as a section within the association under requirements of Chapter IV, MSMA By-Laws."

Again, for the reasons addressed above, your reference committee is in accord with this amendment and recommends the adoption of Resolution No. 9.

The report of the reference committee was adopted.

RESOLUTION NO. 10, PATIENT COMPENSATION PROGRAM

Dr. William E. Godfrey, II:

WHEREAS, The malpractice problem is not yet a crisis in Mississippi, but we delude ourselves if we think that it will not rapidly become one. Therefore, we should seek a solution while there is time remaining to initiate a rational approach without the pressures induced by a crisis invoked time-limit;

WHEREAS, The Mississippi State Medical Association's current objectives in this year's legislative session are worthy and a step in the right direction but only, we fear, a small step. Of the several bills proposed, only a few will pass unchanged. Even if all the bills requested passed unchanged, experience in other states indicates that little relief would be afforded and malpractice rates would continue to soar;

WHEREAS, As we see it there are two possible ultimate solutions: (1) The federal government and HEW are waiting in the wings to solve our problem for us; and (2) a nationwide but state operated medical injury compensation plan similar to the present workmen's compensation plan. Pertinent points concerning a medical injury compensation plan would be:

1. Standard compensation for standard injury without regard to "fault."
2. Injured patient could not sue a covered physician.
3. The program would be administered by an impartial board responsible to the legislature and governor.
4. The board to conduct ongoing studies of medical mishaps to:
   a. eliminate the cause where practical
   b. educate physicians
   c. discipline errant physicians or hospitals
   d. recommend remedial or educational efforts to neutralize mishaps
   e. educate to the imprecision of some medical procedures and the impossibility of 100 per cent success in difficult procedures.

Resolved, That the Mississippi State Medical Association initiate an indepth study of the costs and benefits of a patient compensation program for medical injuries similar to the present workmen's compensation program; and be it further

Resolved, That our delegates to the American Medical Association present a similar motion instructing that body to conduct a similar study.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS, COUNCILS AND BOARD OF TRUSTEES

This resolution was introduced by Dr. William E. Godfrey, II, delegate, Adams County. The resolution provides:

"Resolved, That the Mississippi State Medical Association initiate an indepth study of the costs and benefits of a patient compensation program for medical injuries similar to the present workmen's compensation program; and be it further

"Resolved, That our delegates to the American Medical Association present a similar motion instructing that body to conduct a similar study."

Your reference committee believes as does the sponsor of this resolution that the medical profession should seek new approaches to resolve the professional liability insurance crisis. We recommend adoption of this resolution.

The report of the reference committee was adopted.

AUXILIARY OFFICERS

The speaker presented Mesdames J. Edward Hill of Hollandale, 1975-76 president of the Woman's Auxiliary to the Mississippi State Medical Association, and W. A. Brown, Jr., of Mathiston, 1976-77 president, who addressed the House of Delegates. The ladies reported the change of name of the auxiliary to the Mississippi State Medical Association Auxiliary in order to allow husbands of physicians to join the organization. New president-elect of the auxiliary is Mrs. W. M. Hilbun of Meridian.

1976 MSMA-ROBINS AWARD

President Atkinson presented the 1976 Mississippi State Medical Association-Robins Award for outstanding community service by a physician to Dr. Thomas G. Barnes of Greenville. Dr. Barnes, a surgeon, was cited for his work in high school athletics, YMCA, theater patron, the American Cancer Society, and as a volunteer physician to Haiti. Mr. Willard Duval from the A. H. Robins Company of Richmond, Va., assisted Dr. Atkinson in the presentation of the award, an engraved plaque.

PRESENTATION OF SCIENTIFIC EXHIBIT AWARDS

Dr. James P. Spell, chairman of the Council on Scientific Assembly, announced the awards for outstanding scientific exhibits. "Mammography," by Drs. Elmer J. Harris, James M. Packer, and Robert P. Henderson of the Mississippi Baptist Medical Center in Jackson received the first prize Aesculapius Award, an engraved walnut plaque, for best exhibit by members of the association. "Total Joint Reconstruction in the Lower Extremity," by Drs. Paul S. Derian and W. C. Hopper of the University Medical Center in Jackson received the second place award in the member category. "Coronary Arteriosclerosis—Surgical Treatment," by Drs. Charles W. Pearce, White E. Gibson and Rudolph Weichert of New Orleans, was winner of the Scientific Achievement Award, a sculptured bronze medallion, in recognition of the best presentation by a nonmember. "Fiberoptic Endoscopy—Colonoscopy, Esophagoscopy and Gastroduodenoscopy," by Drs. Jack B. Campbell, Edward M. Lowicki and Charles E. Farmer of Jackson, received an honorable mention.

SPECIAL RECOGNITION

Miss Cleta Brinson, official recorder for the House of Delegates for many years, was recognized by the Speaker and given a standing ovation by the House of Delegates.

AMA-ERF

President Atkinson presented the yearly contribution to the American Medical Association-Education and Research Fund by physicians, their families and Ole Miss Medical Alumni to UMC Associate Dean Carl G. Evers. Dr. J. V. Ferguson of Greenwood, medical alumni association president, was also present when the check for $11,945.61 was given to the medical center.

REPORT OF THE REFERENCE COMMITTEE ON RULES AND ORDER OF BUSINESS

Conduct of Business. Your reference committee commends the speaker and vice speaker for the outstanding manner in which they have conducted business before this House of Delegates. We believe that all members will wish to associate themselves in this expression of appreciation.

Resolution. The reference committee desires to offer the following resolution for consideration by the House of Delegates:

WHEREAS, The 108th Annual Session of the Mississippi State Medical Association has been conducted at Jackson, Mississippi, during the period May 3-6, 1976; and

WHEREAS, The annual session has been most profitable and enjoyable for all who have been in attendance; now therefore be it

Resolved, That expressions of deep appreciation are made to the officers, trustees and Council on Scientific Assembly for the top grade educational scientific programs; to the management of the Downtown Holiday Inn; to the press, radio and television for coverage of our activities; to the gra-

cious ladies of the auxiliary who always contribute so substantially to our meetings; to the technical exhibitors and their professional service representatives; to our scientific exhibitors who have contributed to our learning and instruction; to our distinguished guests, particularly Max Parrott of Portland, Oregon, president of the American Medical Association; and to all who have shared in the responsibilities of planning, organizing and conducting this great annual session.

Your refcrence committee recommends adoption of this resolution.

The report of the reference committee was adopted.

REPORT OF THE ELECTION OF OFFICERS

President-elect: James O. Gilmore, Oxford

Vice Presidents: J. Edward Hill, Hollandale; Hardy B. Woodbridge, Jackson; and Brantley B. Pace, Monticello

Secretary-Treasurer: J. Elmer Nix, Jackson (1979)

Delegate to AMA: Joseph B. Rogers, Biloxi (1978)

Alternate Delegate to AMA: James V. Ferguson, Greenwood (1978)

Editor: W. Moncure Dabney, Crystal Springs (1978)

Associate Editor: George H. Martin, Vicksburg (1978)

Board of Trustees: John R. Lovelace, Batesville, District 2; Robert S. Caldwell, Tupelo, District 3; and Whitman B. Johnson, Clarksdale, District 1 (1979)

Council on Budget and Finance: William C. Gates, Jr., Columbus; and Sidney O. Graves, Natchez (1979)

Council on Constitution and By-Laws: Mary J. Ward, Corinth (1979)

Judicial Council: W. Richard Campbell, Columbia; David R. Steckler, Natchez; and Dewey H. Lane, Pascagoula (1979)

Council on Legislation: Ed Pennington, Ackerman; George L. Arrington, Jr., Meridian; and Calvin T. Hull, Jackson (1979)

Council on Medical Education: Whitman B. Johnson, Clarksdale; M. Beckett Howorth, Oxford; David B. Ellis, New Albany; James E. Booth, Eupora; Carl G. Evers, Jackson; William M. Hilbun, Meridian; W. Boyce White, Laurel; William E. Godfrey, II, Natchez; and Karl B. Horn, Pascagoula

Council on Medical Service: Joseph C. Hillman, Brookhaven; Larry H. Day, Hattiesburg; and Charles N. Floyd, Gulfport (1979)

Mississippi State Board of Health-District 6, nominees to governor for unexpired term ending December 31, 1977: Charles R. Jenkins, Laurel; Andrew K. Martinolich, Jr., Bay St. Louis; William E. Weems, Laurel

OFFICIAL ATTENDANCE

The official attendance was announced as being 960 which included 503 members, 22 physician guests, 2 interns, 36 residents, 15 medical students, and 67 guests (non-physician). Others included 161 exhibitors, 142 Auxiliary members and 12 staff.

CLOSING CEREMONIES

There being no further business, the speaker returned the gavel to President Atkinson. The Oath of Office was administered to Dr. Lyne S. Gamble, the president-elect, by Dr. James O. Gilmore, chairman of the Board of Trustees, after which Dr. Gamble addressed the House of Delegates.

Mrs. James Grant Thompson of Jackson presented the Thompson Memorial Past President's Pin to Dr. Atkinson.

The House of Delegates was adjourned *sine die* at 12:25 o'clock in the afternoon, May 6, 1976.

MALPRACTICE NOTES

Diagnosis error tops malpractice claims rather than mistakes like leaving a sponge or scissors in the patient . . . specialists are sued most . . . 3 per cent of claimants get 63 per cent of $105 million paid in 7 month period . . . doctors now keeping more extensive records which the government says has added $4 billion to health care costs.

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, June 26-July 1, Dallas. Clinical Convention, Dec. 4-8, 1976, Philadelphia. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

La.-Miss. O. and O. Society, April 28-May 1, 1977, Point Clear, Ala. Arthur Hays, M.D., Secy., 3017 13th St., Gulfport 39501.

STATE AND LOCAL

Mississippi Academy of Family Physicians, Annual Meeting, July 7-10, 1976, and July 6-9, 1977, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 109th Annual Session, May 2-5, 1977, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Smith, Yazoo.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Gerald A. Smith, Secy., P.O. Box 128, Sumner 38957. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. A. K. Martinolich, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Reginald P. White, Secy., East Mississippi State Hospital, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, April, June, August, October, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., Jefferson Davis Memorial Hospital, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. D. Stanley Hartness, Jr., Secy., 314 Adams St., Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Lee H. Rogers, Secy., 610 Brunson Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, October. Cherie Friedman, Secy., 1004 Jackson Ave., Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. James H. Sams, Secy., P.O. Box 1381, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, May, July, September, November. Dewey Laner, Secy., Doctors Plaza, Suite 206, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. John L. Smith, Secy., No. 1 Medical Blvd., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

When the same patient makes your office a merry-go-round of somatic complaints



Adapin® (doxepin HCl) may be what she needs

I'm so jumpy, I'm afraid of my own shadow.

I have these headaches almost everyday—I can't understand it, I never used to have them.

Doctor, is it right that I should be so constipated all the time?



Anxiety/depression could be the basis of her somatic complaints
You know the type. She's got a new symptom every visit. And there's never any physiological basis. When you see the chronic "complainer," a diagnosis of depression may be considered . . . and an Rx for Adapin.

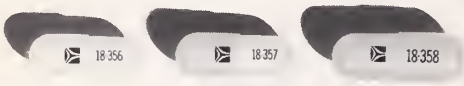
Adapin allays anxiety; improves sleep; brightens the outlook
Adapin can often help the chronic "complainers" get positively reinvolved with life. Adapin almost immediately allays symptoms of anxiety and tension. And from the earliest days it makes it easier for the patient to get to sleep—helps her stay asleep longer. And where there is underlying depression, Adapin usually begins to lift it within three or four weeks.

Please see following page for prescribing information

ADAPIN®
(Doxepin HCl)
Capsules, 10 mg, 25 mg and 50 mg

PENNWALT

ADAPIN®
(Doxepin HCl)



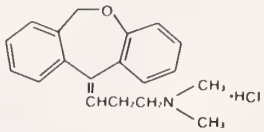
10 mg. **25 mg.** **50 mg.**

Usual optimum dosage is 75 to 150 mg. per day.

Prescribing information:

DESCRIPTION

Adapin (doxepin HCl) is an isomeric mixture of N, N-dimethyl-dibenz(b,e) oxepin- $\Delta^{11(6H)}$, γ propylamine hydrochloride.



ACTIONS

Adapin has a variety of pharmacological actions with its predominant action on the central nervous system. While its mechanism of action is not known, studies have demonstrated that it is neither a monoamine oxidase inhibitor nor a primary stimulant of the central nervous system.

INDICATIONS

In controlled clinical evaluations, **Adapin** has shown marked antianxiety and significant antidepressant effects. **Adapin** has been found to be well tolerated even in elderly patients.

Adapin is indicated for the treatment of patients with:

1. Psychoneurotic anxiety and/or depressive reactions.
2. Mixed symptoms of anxiety and depression.
3. Anxiety and/or depression associated with alcoholism.
4. Anxiety associated with organic disease.
5. Psychotic depressive disorders including involutional depression and manic-depressive reactions.

Target symptoms of psychoneurosis that respond particularly well to **Adapin** include: anxiety, tension, depression, somatic symptoms and concerns, insomnia, guilt, lack of energy, fear, apprehension and worry.

Because **Adapin** provides antidepressant as well as antianxiety effects, it is of particular value in patients in whom anxiety masks depression. Patients who have not responded to other antianxiety or antidepressant drugs may benefit from **Adapin.**

In a large series of patients systematically observed for withdrawal symptoms, none were reported—a finding which is consistent with the virtual absence of euphoria as a side effect and the lack of addictive potential characteristic of this type of chemical compound.

CONTRAINDICATIONS

Because **Adapin** has an anticholinergic effect, it is contraindicated in patients with glaucoma or a tendency toward urinary retention.

Use of **Adapin** is contraindicated in patients who have been found hypersensitive to it.

WARNINGS

Usage in Pregnancy—Adapin has not been evaluated in pregnant patients. Therefore, it should not be used during pregnancy unless, in the judgment of the physician, it is essential to the welfare of the patient.

In animal reproduction studies of **Adapin,** gross and microscopic examination of the offspring gave no evidence of drug-related teratogenic effect. Following doses of up to 25 mg./kg./day for 8 to 9 months, no changes were observed in the number of live births, litter size, or lactation. A decreased rate of conception was observed when male rats were given 25 mg./kg./day for prolonged periods—an effect which has occurred with other psychotropic drugs and has been attributed to drug effect on the central and/or autonomic nervous systems.

Usage in Children—The use of **Adapin** in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors—Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with **Adapin.** The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

PRECAUTIONS

Drowsiness may occur with **Adapin (doxepin HCl);** therefore, patients should be warned of its possible occurrence and cautioned against driving a motor vehicle or operating hazardous machinery while taking the drug.

Patients should also be cautioned that the effects of alcoholic beverages may be increased.

Since suicide is an inherent risk in depressed patients and remains a risk through the initial phases of improvement, depressed patients should be closely supervised.

Although **Adapin** has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Compounds structurally related to **Adapin** can block the effects of guanethidine and similarly acting compounds. However, at the usual clinical dosages, 75 mg. to 150 mg. per day, **Adapin** has been given concomitantly with guanethidine without blocking its antihypertensive effect. But at dosages of 300 mg. per day or higher, **Adapin** has exerted a significant blocking effect.

Adapin, like other structurally related psychotropic drugs, potentiates norepinephrine response in animals. But this effect has not been observed with **Adapin** in humans, which is in accord with the low incidence of tachycardia reported clinically.

ADVERSE REACTIONS

Anticholinergic Effects: Dry mouth, blurred vision and constipation have been reported. These are usually mild, and often subside as therapy is continued or dosage reduced.

Central Nervous System Effects: Drowsiness has been observed. It usually occurs early in the course of therapy and tends to subside as therapy continues. (See Dosage and Administration section.)

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported adverse effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects (such as increased sweating), weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

DOSAGE AND ADMINISTRATION

In most patients with mild to moderate anxiety and/or depression: 10 mg. to 25 mg. t.i.d. to start. A starting dosage of 10 mg. t.i.d. for a period of four days may reduce the initial drowsiness experienced by some patients, and may be tried in cases where drowsiness is clinically undesirable. Decrease or increase the dosage at appropriate intervals according to individual response. Usual optimum dosage is 75 mg. to 150 mg. per day.

In some patients with mild symptomatology or emotional symptoms accompanying organic disease, dosage as low as 25 mg. to 50 mg. per day has provided effective control.

In more severe anxiety and/or depression: 50 mg. t.i.d. may be required to start—if necessary, gradually increase to 300 mg. per day. Additional effectiveness is rarely obtained by exceeding 300 mg. per day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

OVERDOSAGE

Symptoms—An increase of any of the reported adverse reactions, primarily excessive sedation and anticholinergic effects such as blurred vision and dry mouth. Other effects may be: pronounced tachycardia, hypotension and extrapyramidal symptoms.

Treatment—Essentially symptomatic; supportive therapy in the case of hypotension and excessive sedation.

HOW SUPPLIED

Each capsule contains doxepin, as the hydrochloride: 10 mg. (NDC 0018-0356), 25 mg. (NDC 0018-0357) and 50 mg. (NDC 0018-0358) capsules in bottles of 100, and 1000.

Brighter days ahead for your psychosomatic complainers



PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603

Constitution and By-Laws of the Mississippi State Medical Association

CONSTITUTION

Preamble

That more may live longer in the richness and comfort of health; that pain, suffering, and disease may be eradicated to the extent made possible by scientific medical knowledge; that the standards of the medical profession may be maintained on the highest plane of honor, we dedicate ourselves as physicians through this Association. Among us, membership is a privilege, earned by professional qualification, personal honor, and selfless service; it is not a right vested superficially nor by statutory licensure. Truth shall be our quest; diligence, our staff; and service, our purpose.

Article I
NAME OF THE ASSOCIATION

The name and title of this Association shall be the Mississippi State Medical Association.

Article II
PURPOSE OF ORGANIZATION

The purpose of this Association shall be to federate and into one compact organization the entire medical profession of the state of Mississippi and to unite with similar associations in other states to form the American Medical Association, with a view toward the extension of medical knowledge, and to the advancement of medical science; to the elevation of the standard of medical education, and to the enactment and enforcement of just medical laws, to the promotion of friendly intercourse among the physicians and to guarding and fostering of their opinion in regard to the great problems of medicine, so that the profession shall become more honorable and capable within itself, and more useful to the public in the prevention and care of disease, and in the prolonging of and adding comfort to life.

The purpose of this Association shall be to promote scientific medical research and practice and it shall be a nonprofit organization.

Article III
COMPONENT SOCIETIES

Component Societies shall consist of those societies which hold charters from the Association.

Article IV
MEMBERSHIP

Section 1. Members of the Mississippi State Medical Association. Members shall be active, associate, emeritus, or honorary, according to requirements and provisions of the By-Laws. There may also be invited guests. Membership other than associate and honorary shall be construed as active in connection with the rights and privileges accruing therefrom.

Section 2. Guests. Any physician not a resident of the state may become a guest during any annual session upon invitation of a member of the Association, and shall be accorded the privilege of participating in all the scientific work of that session.

Article V
SESSIONS AND MEETINGS

Section 1. The Association shall hold an annual session during which there shall be held daily not less than two general meetings, which shall be open to all registered members and guests.

Section 2. The time and place for holding the annual session shall be fixed by the House of Delegates, but in emergencies, the Board of Trustees shall have the power to fix, or change, either the time or the place, or both of the annual session.

Article VI
GENERAL OFFICERS

Section 1. The general officers of this Association shall be President, President-elect, three Vice-Presidents, one from each Supreme Court District, Secretary-Treasurer, Speaker, Vice Speaker, and Editor.

Section 2. The President, President-elect, and Vice-Presidents shall hold terms of one year. The Secretary-Treasurer, Speaker, Vice Speaker and Editor shall be elected for terms of three years.

Section 3. The officers of this Association shall be elected by the House of Delegates on the last day of the annual session following the adjournment of the general meeting, but no person shall be elected to any such office who has failed to attend one of the past two or current annual sessions and who has not been a member for the past two years.

Section 4. In addition to these general officers, there shall be an Executive Secretary who need not be a physician or member of the Association. He shall be appointed by the Board of Trustees and shall serve at the pleasure of the Association. His compensation and expenses for duties performed shall be fixed by the Board of Trustees and confirmed by the House of Delegates.

Article VII
EXECUTIVE OR CENTRAL OFFICES

The Executive Secretary shall maintain in the city of Jackson suitable offices for the discharge of his duties and for conducting the administrative affairs of the Association.

Article VIII
HOUSE OF DELEGATES

The House of Delegates shall be the legislative, business, and policy-making body of the Association and shall consist of (1) delegates selected by the component societies under authorized apportionment, (2) the general officers of the Association, (3) all past presidents, provided they still be members in good standing of the Association, (4) members of the Board of Trustees and Councils, and (5) elected committees, Delegates and Alternate Delegates to the American Medical Association and members of the State Board of Health, all of whom must be members of this Association.

Article IX
BOARD OF TRUSTEES

The Board of Trustees shall be the executive and governing body of the Association during vacation of the House of

Delegates and shall perform such duties as are prescribed by law governing directors of corporations and in the By-Laws of the Association. The Board shall consist of 12 members, one from each of the nine Association Districts, except Association District V which is authorized two members, elected for terms of three years each and the President and Immediate Past President. A Trustee shall not serve more than two consecutive terms and no member shall be eligible for re-election to the Board of Trustees after serving two consecutive terms until that individual has been off the Board for at least six years.

Article X
FUNDS AND EXPENSES

Funds for meeting the expenses of the Association shall be arranged for by the House of Delegates by annual dues, per capita assessments upon the membership, and by voluntary contributions. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, publications, and for any other purpose approved by the House of Delegates.

Article XI
THE SEAL

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII
AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been sent officially to each component society at least two months before the session at which final action is taken.

BY-LAWS

Chapter I
MEMBERSHIP

Section 1. Eligibility. Each component society of the Mississippi State Medical Association shall judge the qualifications of candidates for election to membership therein, which shall be restricted to those persons who hold the degree of Doctor of Medicine from an appropriately accredited source as defined by the American Medical Association, or in lieu thereof, a foreign degree in medicine which is an acceptable equivalent to the Board of Trustees and shall be a citizen of the United States. All candidates for any degree of membership other than associate or honorary must be legally licensed to practice medicine in Mississippi. Persons who obtained this degree prior to January 1, 1917, need not comply with this requirement but must be licensed to practice medicine in Mississippi or, if offering to practice in Mississippi must be eligible for license by reciprocity and be a member in good standing of a constituent (state) association of the American Medical Association. Membership in a component society, evidenced by the payment of dues for the current year, shall be a prerequisite to membership in the Association, except that a physician upon his initial application for membership in a component society of the Association shall be required to undergo a waiting period of ninety (90) consecutive days from the date he begins the practice of medicine in the geographical area of the component society before he may be elected to membership in the component society. No physician shall be eligible for membership who has been convicted of or who has plead guilty to either a felony or a violation of a state or federal narcotics law. The duly certified court record shall be *prima facie* evidence of pleas and convictions and cause automatic revocation of membership. No physician shall be eligible for election to or continuation of membership who does not possess a currently effective federal narcotics stamp, provided, however, that physicians in full time government service who need no registration to use, prescribe, and dispense narcotic drugs and those who, by reason of type of practice, employment, inactivity, or retirement, neither prescribe nor dispense narcotics and who for this reason alone have not applied for registration shall be exempt from this requirement. Also, any member of the association who voluntarily surrenders his federal narcotics stamp and places himself in a rehabilitation program recommended by that examining committee of physicians composed under the Mississippi Disabled Physician Act of 1975 shall be exempt from this requirement.

Section 2(a). Good Standing. Only those members in good standing shall be entitled to the rights and privileges of membership. A physician not in good standing may not be elected to office nor exercise the privilege of voting or attending any session of this Association, scientific or otherwise. The name of a physician upon the properly certified roster of a component society which has paid its annual assessment shall be *prima facie* evidence of his right to register at the annual session of the Mississippi State Medical Association. No member shall participate in any of the proceedings of the annual session until he is duly registered. No delegate or other member shall take part in any of the proceedings of an annual session until he has complied with the provisions of this session. (b) Change of State Residence. In the event that a member moves from the State, his membership shall continue until, and lapse at the end of, the current fiscal year, but this provision shall not operate to prevent a physician who moves from the state continuing his membership by payment of all dues and assessments to the state Association). (3) Obligations of Membership. When the Executive Secretary of the Mississippi State Medical Association is officially informed by the secretary of a component society that a physician is not in good standing in the component society, he shall remove the name of the physician from the rolls of the Association. A member shall hold his membership through the component society in the jurisdiction of which he practices, provided that a physician living on or near a county line may hold membership in the society most convenient for him to attend. If the society in which he chooses to secure membership does not exercise jurisdiction over the area of his residence, then permission must be obtained from the jurisdiction society to facilitate his affiliation with the extra-jurisdiction society.

Section 3. Degrees of Membership. Members of the Mississippi State Medical Association shall be divided into the following classifications: Active, emeritus, and associate. (a) Active Membership. Active members shall include all eligible members of component societies in good standing, providing that all dues and assessments in this Association as may be hereinafter prescribed have been received by the Association. (b) Emeritus Members. Any member of the Mississippi State Medical Association who has been an active member for any ten consecutive years and shall have permanently retired from the practice of medicine shall be eligible for election to emeritus membership. Election to emeritus membership for reasons of retirement in the case of permanent and total disability shall merit special consideration but shall be subject to ruling by the Board of Trustees. Election to emeritus membership shall be based on the recommendation of the component society and the approval of the Board of Trustees. (c) Associate Membership. Any commissioned medical officer in the United States Army, United States Air Force, United States Navy, or United States Public Health Service, or any physician in the employ

of the Veterans Administration, not licensed to practice in the State of Mississippi, stationed in Mississippi, members of medical faculties of medical schools in Mississippi, approved by the American Medical Association, who are not licensed to practice in the state, any hospital intern, or any hospital resident in Mississippi, may, on election to associate membership by the component society in whose jurisdiction the physician resides become an associate of the Mississippi State Medical Association. Associate members shall not vote or hold office. (d) Honorary Membership. A layman who has rendered meritorious service may on approval and nomination by the Judicial Council be elected to honorary membership by majority vote of the House of Delegates. Honorary members shall not vote or hold office.

Section 4. Dues and Assessments. A per capita assessment determined by the House of Delegates shall constitute the dues of the Association, which assessment shall be collected from all active members by the respective secretaries of the component societies, provided that new members shall be accepted on payment of three-fourths of annual dues after May 1 and one-half of annual dues after September 1. Each active member shall pay the prescribed dues to the officer designated by the component society for transmittal to the Executive Secretary of the Association. Dues shall include a subscription to the official publication of the Association. (a) Members Excused From Payment. The Board of Trustees may, by majority vote, excuse a member from payment of dues because of undue hardship or similar circumstances warranting special consideration provided that the component society shall have excused in full the payment of dues for periods exceeding one year. Such circumstances shall be interpreted to include extended illness and temporary disability. Members who shall have attained age 70 and who have been active members of the Association for any 10 consecutive years may, upon request, be exempt from dues for life effective January 1 after the 70th birthday, and such exemption shall continue so long as the member continues in good standing in his component medical society. (b) Emeritus Members. Physicians who have been elected emeritus members shall not be required to pay dues in the Association. (c) Payment of Dues and Delinquency. Dues of the Association are due and payable on December 31 of the year prior to that for which dues are prescribed. Failure to pay dues by April 1 of the year for which due shall result in forfeiture of membership privileges and the removal of the member's name from the rolls of the Association. A five dollar ($5.00) reinstatement cost shall be assessed against any member who is delinquent by reason of non-payment of dues after April 1 of the year for which dues are payable. A member in good standing who is called to active duty with the Armed Forces of the United States other than in the regular component shall be carried as an active member without payment of dues until such time as he is released from military service.

Section 5. American Medical Association. Members of this Association desiring to be members of the American Medical Association may pay the dues or apply when eligible, for legal exemption from the dues of the American Medical Association. Those desiring to do so may pay their dues to the Executive Secretary whose duty shall be to transmit them to the American Medical Association and to obtain proper credits and receipts therefor.

Section 6. Revocation of Emeritus or Associate Membership. Any emeritus or associate membership may be revoked by two-thirds vote of the House of Delegates when, in the opinion of the House of Delegates, the conduct or actions of the emeritus or associate member violates any of the principles of the code of ethics or whose conduct or actions are not becoming to the honor conferred.

Chapter II
ANNUAL AND SPECIAL SESSIONS

Section 1. Time and Place. An annual session shall be held as required by Article V, Section 1, the Constitution of the Mississippi State Medical Association, which session shall in any event be held prior to the annual session of the American Medical Association. The place of the state session shall be fixed in accordance with Article V, Section 2, the Constitution of the Mississippi State Medical Association.

Section 2. Special Session. A special session of the Association or of the House of Delegates may be called by the President, with the approval of the Board of Trustees. The Board of Trustees is empowered to call a special session by majority concurrence.

Section 3. Inviting an Annual Session. A component society desiring the Association and House of Delegates to meet in annual session in a city within its jurisdiction may submit an invitation in writing or verbally through its representative to the House of Delegates at the annual session concerned with the selection of the site for the next regular scheduled meeting. The dates and site of the annual session selected may be changed by majority vote of the Board of Trustees in an emergency requiring such a change.

Section 4. Registration Privileges. Only the following shall be permitted to register at any session:

(a) Active members
(b) Emeritus members
(c) Associate members
(d) Honorary members
(e) Invited guests
(f) Medical students of American Medical Association approved medical schools who are certified to the Executive Secretary of the Association by their respective deans.
(g) Interns and residents who are graduates of American Medical Association approved medical schools and who are connected with an approved hospital and who are certified to the Executive Secretary of the Association by their respective hospital superintendents in event they are not associate members of the Association.
(h) Commissioned medical officers of the United States Armed Forces who are on active duty and who if not associate members are certified to the Executive Secretary by their Post or Base Surgeons or Commanding Officers.

Section 5. Indebtedness. A member shall not be permitted to register unless all current indebtedness to both the Association and component of proper jurisdiction has been paid.

Section 6. Admittance. Admittance to any meeting of the House of Delegates, any scientific section, or any of the various exhibits at an annual session of the Association shall be limited to members in good standing, duly registered and invited guests, members in good standing of the Woman's Auxiliary to the Mississippi State Medical Association, duly accredited and registered members of the Press, and accredited technical and scientific exhibitors.

Chapter III
GENERAL MEETING

Section 1. Participation. The general meeting shall include all registered members and guests, who shall have equal rights to participate in the proceedings and discussions, but no member shall vote on any question coming before a sec-

tion of the general meeting except those who have registered as members of such sections. Each section of the general meeting shall be presided over by its chairman. The address of the President and the Distinguished Service Oration shall be delivered before the general meeting at such time and place as may be arranged.

Section 2. Order. The order of exercise, papers, and discussions as set forth in the official program shall be followed from day to day until it has been completed. But no section shall be allowed to place more than five papers on its program, nor more than two invited guest essayists (out-of-state or non-member). When a section program is not completed within the time assigned, it shall not be allowed to continue into that assigned to another section.

Section 3. Time Restrictions. No address or paper before the Association, except those of the President and Orator, shall occupy more than twenty minutes in its delivery, except that guests may be allowed thirty minutes; and in formal discussion no one shall speak more than five minutes; and in informal discussion no one shall speak more than three minutes and not more than one time.

Section 4. Essayists. With the exception of the invited guests, the essayists must be members of the Association. No name shall appear more than once on the printed program to discuss a paper before the regular scientific sections unless such person qualifies for membership as provided in these By-Laws.

Section 5. Papers. All papers read before the Association shall be its property. Each paper must be read by its author, and must be deposited with the Secretary when read.

Section 6. Failure to Read Paper. No author listed on the program who fails to read a paper at the session may be allowed a place on the program of the next annual session, but if the author, being unable to attend, shows his good intent by forwarding his paper to the Secretary before the annual session, he shall not suffer the penalty.

Chapter IV
SCIENTIFIC SECTIONS

Section 1. Designation of Sections. The scientific sections of the Association shall be as follows: (a) Section on Medicine, (b) Section on Surgery, (c) Section on Preventive Medicine, (d) Section on Eye, Ear, Nose and Throat, (e) Section on Pediatrics, (f) Section on Obstetrics and Gynecology, (g) Section on General Practice, (h) Section on Anesthesiology, (i) Section on Radiology, (j) Section on Pathology, (k) Section on Psychiatry, and (l) Section on Dermatology.

Section 2. Section Officers. Each scientific section of the Association shall, as the last order of business during its regular meeting, elect a chairman who shall serve for a period of one year. A majority of votes cast shall be necessary to elect. Additionally, each section shall elect a secretary whose term of office shall be for a period of three years and so arranged that secretaries shall be elected by their respective sections at the same annual meeting as follows: (1) Sections on General Practice, Anesthesiology, and EENT, (2) Sections on Obstetrics and Gynecology and Preventive Medicine, and (3) Sections on Pediatrics, Surgery, and Medicine.

Section 3. Program. The Council on Scientific Assembly shall place any paper in its proper section. The Council shall so arrange the program that no one section shall be given precedence over others two years in succession.

Chapter V
HOUSE OF DELEGATES

Section 1. Apportionment and Representation. Each organized county shall be entitled to representation in all regular and special sessions of the House of Delegates, one delegate and one alternate for each fifty members in the county and one delegate and one alternate for each fraction thereof, but each organized county holding a charter from this organization having made its annual report and paid its assessments, as provided in this Constitution and By-Laws shall be entitled to at least one delegate and alternate, said alternate delegates to act only in the absence of the delegate or delegates from the respective counties. No county in a component society shall be without representation in the House of Delegates; each shall be entitled to one delegate and one alternate without regard to total membership. No alternate may be seated at any regular or special session of the House of Delegates unless the delegates elected from that county shall be absent or otherwise unable to participate in the proceedings. In the event that neither the delegate nor the alternate is able to attend the regular or special session to which they have been accredited, then any *bona fide* resident of the county may, if properly registered, qualify himself as a delegate. No representative of the component society shall be seated in the House of Delegates until all his dues, assessments, and obligations to the component society have been paid. Delegates and alternates shall be elected by their respective component societies for terms of not less than two years and shall assume office on the first day of the annual session following their elections; they shall be *bona fide* residents of the counties which they represent. Their names shall be reported to the Central Office of the Association not later than thirty days prior to the first day of the annual session. Representatives of component societies shall be seated in the House of Delegates only following their proper registration of credentials from the component societies they represent.

Section 2. Meetings and Attendance. The House of Delegates shall meet annually on the first day of the annual session of the Association. The House of Delegates shall meet for the conclusion of business on the last day of the annual session immediately following the adjournment of the last general or scientific session, provided that these requirements shall not operate to prevent such other meetings of the House of Delegates during the annual session as the House itself may order or the President or Speaker may deem necessary, but no such meetings may be called at times which would conflict with the scheduled general or scientific session. Duly registered members and guests may attend all meetings of the House of Delegates provided that they occupy a distinctly separate section of the meeting hall or auditorium and further provided that they shall not be permitted to participate in any phase of the meeting of the House of Delegates except on invitation of that body. By majority vote, the House of Delegates may enter into executive session, during which time only qualified delegates and officers of the Association may remain in attendance.

Section 3. Quorum. A three-fifths majority of registered and duly seated delegates of this Association shall constitute a quorum.

Section 4. Order of Business. The order of business shall be conducted at the pleasure of the House of Delegates, provided it shall not be in conflict with either these By-Laws or the Constitution. Meetings shall be conducted according to *Sturgis Standard Code of Parliamentary Procedure,* and within the bounds of courtesy and this Constitution and By-Laws. Generally, the order of business shall be:

(1) Adoption of the Transactions of the previous meeting.
(2) Reports of Boards, Councils and Committees.
(3) Reports of Presidential Committees.
(4) Special Orders.
(5) Unfinished Business.
(6) New Business.

Section 5. Memorials and Resolutions. No memorials or resolutions shall at any time be issued in the name of the Mississippi State Medical Association by any officer or member thereof until such memorial or resolution has been approved and adopted by the House of Delegates or Board of Trustees.

Section 6. Duties and Responsibilities. It shall, through its officers and otherwise, give diligent attention to foster the scientific work and spirit of the Association, and shall constantly study and strive to make each annual session a stepping stone to future ones of higher interest. It shall consider and advise the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto. It shall make careful inquiry into the condition of the profession of each county in the state, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in the counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality, and shall continue these efforts until every physician in every county in the state has been brought under medical society influence. It shall encourage postgraduate work in medical centers, as well as home study and research, and shall endeavor to have the results utilized and intelligently discussed in the component societies. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body, the term of office to begin on January 1 of the year following that of the elections and continuing for two successive years. It shall, upon recommendation of the Board of Trustees, provide and issue charters to counties organized to conform to the spirit of the Constitution and By-Laws.

Section 7. Reference Committees. Business brought before the House of Delegates will normally be referred by the Speaker for hearing, debate, and recommendation to a reference committee. Sufficient reference committees shall be appointed by the President to expedite and assist in the deliberations of the House of Delegates. Such committees shall consist of not less than three nor more than five members, all of whom shall be members of the House of Delegates, who shall serve only during the regular or special session for which appointed. Any member of the Association shall have the privilege of appearing before a reference committee on any issue being considered. Additionally, reference committees may permit the appearance of any individual who, in the opinion of the committee, can assist its deliberations.

Chapter VI
ELECTION OF OFFICERS

Section 1. Ballot. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect.

Section 2. Nominations. The House of Delegates on the first day of the annual session shall select a Committee on Nominations consisting of nine members of the House of Delegates, one from each Association District. It shall be the duty of this committee to consult with the members of the Association and to hold one or more meetings at which the best interests of the Association and of the profession of the state for the ensuing year shall be carefully considered. The committee shall nominate to the House of Delegates three names for each general officer vacancy and two names for all other offices. No two candidates for President-elect may be named from the same county. Nominations for appointment to membership on the Mississippi State Board of Health shall be made by the House of Delegates in accordance with Section 7024, Mississippi Code of 1942, provided that six names shall be submitted, three of whom shall be elected and their names submitted to the Governor as nominees from each district, provided no member shall be nominated who has served two consecutive terms.

Section 3. Report of Nominations. The House of Delegates shall receive the report of the Committee on Nominations and elect officers, Trustees, and Council members on the last day of the annual session.

Section 4. Nominations from the Floor. Nothing in this Chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

Section 5. Executive Secretary. The Board of Trustees shall select and appoint an Executive Secretary as elsewhere prescribed in the Constitution and By-Laws of the Association.

Chapter VII
DUTIES OF OFFICERS

Section 1. President. The President shall have general supervision over all meetings of the various bodies of the Association, shall appoint all committees not otherwise provided for, shall deliver an annual address at such time and place as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall fill by appointment all vacancies occurring during his tenure of office among the general officers and on the Board of Trustees and Councils and shall be empowered to appoint such committees on an *ad hoc* basis as may be desired or required to conduct the affairs of the Association. He shall be an *ex officio* member of all Councils and committees. He shall be the real and acknowledged head, as well as the personal representative, of the medical profession of the State of Mississippi during his term of office, and insofar as practicable, shall visit by appointment the various sections of the state and the component societies of the Mississippi State Medical Association and assist the Trustees in their tasks of aiding and strengthening the component societies and in making their work more useful.

Section 2. President-elect. The President-elect shall be in charge of the work of organization, including membership, under the direction of the President, and shall exercise these duties and advise with the Vice Presidents and with the Board of Trustees in this phase of their activity. He shall be an *ex officio* member of all Councils and committees. He shall succeed to the presidency upon the event of the death, resignation, or removal from office of the President. This automatic succession shall not operate to disqualify him from serving the next regular term of office unless he has served more than six months as President.

Section 3. Vice Presidents. The Vice Presidents shall assist the President in the discharge of his duties. They shall further assist the President-elect in the work of organization, including membership in their respective areas, and in promoting the welfare of the Association and the profession of the state.

Section 4. Speaker. A Speaker shall be elected for a term of three years. This officer may be chosen from the membership of the Association, irrespective of any affiliation with the House. The Speaker shall familiarize himself with the rules and usages of parliamentary procedure, with the laws of the House. On him shall devote the duty of bringing before the House through the various officers and chairmen all

reports and other matters that are to receive its attention. He shall preside at all meetings of the House and perform the duties usual to the position and office of chairman except in the appointment of committees, which shall be the privilege of the President.

Section 5. Vice Speaker. A Vice Speaker shall be elected for a term of three years to run concurrently with that of the Speaker. The Vice Speaker shall assist the Speaker in all duties prescribed in these By-Laws.

Section 6. Secretary-Treasurer. The Secretary-Treasurer shall be elected for a term of three years. He shall perform such duties ordinarily devolving on a secretary of a corporation by law, custom, or parliamentary usage and shall enjoy the rights and perform such other duties as may be granted or imposed in the Constitution and these By-Laws. He may delegate such duties as are herein described to the Executive Secretary who shall be responsible therefor. He shall be an *ex officio* member of all Councils and committees.

Section 7. Executive Secretary. The Executive Secretary shall be appointed by the Board of Trustees and shall serve at the pleasure of the Association. He need not be a member of the Association nor a physician. He shall maintain a Central Office for the Association and shall be responsible for the management and proper functioning of the Central Office to the President of the Association and the Board of Trustees. He shall attend all sessions and meetings of the Association, the House of Delegates, the Board of Trustees, and shall serve at all times to perform such other duties as may be deemed beneficial to the Association by the President and Board of Trustees. He shall assist elected officers, Councils, committees, and Trustees in the performance of their duties. Under instructions from the President, he shall conduct a comprehensive program of public education and all such other activities as may disclose favorably to the public at large the aims, objectives, and goals of service of the medical profession in Mississippi. He shall, when requested, place himself in position to assist any of the component societies of the Association and he shall attend meetings of the component societies when invited by officers thereof. He shall be made custodian of records, books and papers belonging to the Association and he shall keep account of and promptly place under the supervision of the Secretary-Treasurer such funds as may be delivered into his hands in the name of the Association. He shall give bond at the expense of the Association in such amount as may be required. He shall provide for the registration of the members and delegates at the annual session and cooperate in preparing for and arranging all functions of the Association, including the annual session. He shall procure an exact transcript of all proceedings of the House of Delegates. He shall maintain a register of all legal practitioners in Mississippi and he shall maintain detailed and exact records of the membership with regard to component societies, the Mississippi State Medical Association, and the American Medical Association. He shall issue evidence of membership to each physician who pays the annual assessment and is accepted in the Mississippi State Medical Association. He shall maintain close and complete liaison with the American Medical Association and shall keep the component societies informed of activities, programs, and mandates of both the state Association and the American Medical Association. He shall publish from the Central Office such memoranda, bulletins, and miscellaneous publications as may be directed by the President, the Board of Trustees, and the House of Delegates. He shall conduct the official correspondence of the Association as he may be directed. He shall employ such assistants as may be required, upon authorization of the Board of Trustees. He shall supply each component society with blank forms to be used in connection with membership and reports. He shall maintain records of monies paid by the component societies for assessments and dues. He shall prepare and publish under the direction of the President and Board of Trustees such programs as may be necessary for official functions of the Association. He shall be reimbursed for expenses incurred in the performance of his duties, separately and in addition to his regular compensation.

Chapter VIII
BOARD OF TRUSTEES

Section 1. Board of Trustees. The Board of Trustees shall be the executive and governing body of the Association during vacation of the House of Delegates. It shall consist of 12 members, one from each Association District, except Association District V which is authorized two members, whose terms of office shall be three years. A Trustee shall not serve more than two consecutive terms. No member shall be eligible for re-election to the Board of Trustees after serving two consecutive terms until that individual has been off the Board for at least six years. The President and Immediate Past President of the Association shall also serve on the Board of Trustees. During vacation, the Board of Trustees shall exercise the powers conferred upon the House of Delegates by the Constitution and these By-Laws, provided that in the exercise of these powers thus conferred, the Board of Trustees shall neither consider nor act to contravene any action, mandate, or policy of the House of Delegates which may still be in effect.

Section 2. Officers of the Board. The Board of Trustees shall elect from its membership a Chairman, a Vice Chairman, and a Secretary for terms of one year during the last day of the annual session following adjournment of the House of Delegates. These officers of the Board shall compose its Executive Committee. The duties of the Secretary may be delegated to the Executive Secretary who shall maintain such special records and transcripts of meetings as the Board may desire.

Section 3. Meetings of the Board. The Board of Trustees shall meet daily during the annual session of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of any three members of the Board.

Section 4. Executive Committee. The Executive Committee of the Board of Trustees shall be empowered to act in behalf of the Board on all matters delegated to it by majority vote of the Board. The acts of the Executive Committee, however, shall be subject to confirmation by the Board.

Section 5. Reports of the Board of Trustees. The Board of Trustees shall make an annual report to the House of Delegates and such supplemental reports as necessity may require at a time designated in the regular transaction of the business of the House. The report shall be made by the Chairman, the Vice Chairman, the Secretary, or the Executive Secretary. The reports of the Board shall be made a portion of the annual transactions and proceedings of the Association.

Section 6. Duties of Trustees. Each Trustee shall be organizer and arbiter for his Association District. He shall visit the component medical societies within his District during each year and shall make an annual report of his activities and of the condition of the medical profession of each county of his District. Each Trustee shall be reimbursed for expenses incurred by him in traveling within his District or attending special meetings in the performance of his official duties, which will be allowed upon presentation of an itemized and documented account. This provision shall not be construed to include his expenses in attending the annual session of the Association.

Section 7. Public Policy. The Board of Trustees shall have the right to communicate the views of the medical profession and of the Association in the State of Mississippi with regard to matters of medical science, health, sanitation, and allied spheres of activity. It shall approve all memorials and resolutions issued but shall not issue memorials and resolutions heretofore prohibited in these By-Laws.

Section 8. Association Districts. The State of Mississippi shall be subdivided into Association Districts by counties, provided that all counties in a component society shall be in one Association District. These districts are defined as follows:

District 1: Bolivar, Coahoma, Humphreys, Leflore, Quitman, Sunflower, Tallahatchie, Tunica, and Washington.

District 2: Benton, DeSota, Lafayette, Marshall, Panola, Tate, Tippah, and Yalobusha.

District 3: Alcorn, Calhoun, Chickasaw, Clay, Itawamba, Lee, Lowndes, Monroe, Noxubee, Oktibbeha, Pontotoc, Prentiss, Tishomingo, and Union.

District 4: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, and Webster.

District 5: Hinds, Issaquena, Leake, Madison, Rankin, Scott, Sharkey, Simpson, Warren, and Yazoo.

District 6: Clark, Kemper, Lauderdale, Neshoba, Newton, and Winston.

District 7: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Pearl River, Perry, Smith, and Wayne.

District 8: Adams, Amite, Claiborne, Copiah, Franklin, Jefferson, Lawrence, Lincoln, Pike, Walthall, and Wilkinson.

District 9: Hancock, Harrison, Jackson, and Stone.

Chapter IX
COUNCILS

Section 1. Councils. Councils of the Association shall be elected standing bodies of the House of Delegates, responsible thereto. There shall be a Council on Medical Service, a Council on Scientific Assembly, a Judicial Council, a Council on Constitution and By-Laws, a Council on Legislation, a Council on Budget and Finance, an Editorial Council, and a Council on Medical Education. A Council member shall not serve more than two consecutive terms. No member shall be eligible for re-election to a Council on which he or she has served two consecutive terms until that individual has been off that council for at least six years.

Section 2. Council on Medical Service. The Council on Medical Service shall be charged with the responsibilities of ascertaining and studying all aspects of medical care in Mississippi. It shall examine and make available all facts, data, and opinion on timely and adequate medical care. It shall investigate social and economic aspects of medical care and report its evaluations and findings. It shall suggest means of distribution of adequate quality medical service to the public consistent with the policies of the Association. It shall act as a factfinding and advisory body of the Association. Under its jurisdictions, there shall be assigned the activities of the Association in medical service, emergency service programs, indigent care, and allied medical agencies. There shall be one member from each Association District elected for a term of three years and so arranged that only three members shall be elected for full terms each year. The Council on Medical Service shall appoint Committees on Maternal and Child Care, Mental Health, Blood and Blood Banking, and Nursing. Each committee shall consist of not less than five nor more than seven members appointed for periods of not less than one nor more than three years.

Section 3. Council on Scientific Assembly. The Council on Scientific Assembly shall be composed of the Secretary-Treasurer and the chairman and secretaries of the several scientific sections. The Secretary-Treasurer shall be chairman of the Council. Upon this Council shall devolve the duties and responsibilities of planning the annual session to include all scientific activity and the programming and scheduling of annual session events. The Council shall be empowered to appoint such committees for terms not to exceed one year as may be necessary to assist in the discharge of these duties.

Section 4. Judicial Council. The Judicial Council shall consist of nine members elected for terms of three years each, one from each Association District. The Judicial powers of the Association shall be vested in this Council whose decision shall be final. The Council shall have jurisdiction in all questions involving membership in the Association, all controversies arising under the Constitution and these By-Laws, interpretation and application of the Principles of Medical Ethics of the American Medical Association, controversies between two or more component societies of the Association and among members of the Association. The Council shall have appellate jurisdiction in questions and controversies referred to the state Association by appropriate and authorized bodies of component medical societies. Appeals shall be perfected within six months following the date of decision by the constituted authority of the component society. The Council, under these several authorities, may conduct such hearings as may be necessary and after due and legal processes may, by majority opinion, censure, suspend, or expel any member for infraction of the Constitution or these By-Laws.

Section 5. Council on Constitution and By-Laws. The Council on Constitution and By-Laws shall consist of three members elected by the House of Delegates for terms of three years each. To this Council shall be referred all suggested amendments and changes in the Constitution and By-Laws of the Association for recommendation to the Board of Trustees and House of Delegates.

Section 6. Council on Legislation. The Council on Legislation shall consist of nine members, one from each association district, elected by the House of Delegates for terms of three years each which are so arranged that three members are elected annually. This Council shall analyze proposed legislation, recommending to the Board of Trustees courses of action for securing laws in the interests of public health, scientific medicine, as well as medical practice. It shall study and report the need for new and remedial legislation designed to serve the best interests of the state and nation. This Council shall be responsible to the Board of Trustees.

Section 7. Council on Budget and Finance. The Council on Budget and Finance shall consist of five members elected by the House of Delegates for terms of three years each which are so arranged that not more than two members shall be elected annually. This Council shall receive reports of the finances of the Association and to it shall be referred all matters pertaining to the annual budget. The Council shall report annually to the House of Delegates, making specific recommendations on the annual budget of the Association. This Council shall be responsible to the Board of Trustees.

Section 8. Editorial Council. The Editorial Council shall consist of the Editor and the Associate Editors, elected by the House of Delegates to serve two years, and the former shall serve as chairman. To this Council shall be referred all reports of scientific subjects and all scientific papers and

discussions presented before the Association and its component societies. The Council shall consider for publication in the official organ of the Association such papers, reports, and other data as may serve to further and advance scientific medicine in Mississippi. It shall exercise editorial authority over the official organ of the Association. This Council shall be responsible to the Board of Trustees.

Section 9. Council on Medical Education. The Council on Medical Education shall consist of one member elected from each association district for terms of office of three years each which are so arranged that no more than three members are elected annually. To this Council shall be assigned the responsibilities of encouraging undergraduate and postgraduate study of medicine, licensure, and facilities for medical education in the state. This Council shall be responsible to the Board of Trustees.

Chapter X
COMMITTEES OF THE BOARD OF TRUSTEES

Section 1. Committees of the Board of Trustees. Standing committees of the Board of Trustees shall consist of the Advisory Committee to the Medical Auxiliary, Peer Review Committee, the Committee on Publications, and the Committee on Medicine and Religion. All committees of the Board of Trustees shall be appointed by the Board for terms specified unless their selection is otherwise prescribed.

Section 2. Advisory Committee to the Medical Auxiliary. The Advisory Committee to the Medical Auxiliary shall consist of three members appointed for terms of three years each. The committee shall be charged with the responsibility of advising the Woman's Auxiliary to the Mississippi State Medical Association on matters of organization and program activity relating to the supportive role of the Auxiliary in its work with the Association.

Section 3. Peer Review. The Committee on Peer Review shall consist of nine members, one from each Association district, appointed for terms of three years each so as to provide for appointment of three members annually. Members of this committee shall not simultaneously serve on any disciplinary body of the Association or its component medical societies. To this committee shall be assigned the work of peer review, including but not limited to resolution of differences between patient and physician, review of the quality of medical care, adequacy and/or reasonableness of fees, whether due or paid from private or public sources, utilization of health care resources, and liaison with private and public sources of medical care financing. The committee is empowered to encourage a response from any member of the Association in writing or by personal appearance, authority to initiate investigations on its own motion, and authority to file charges against a member in the name of the committee before the Judicial Council or a disciplinary body of a component medical society. Under no circumstances, however, shall the Committee on Peer Review exercise any disciplinary function nor shall it be empowered to alter the status or standing of any member. The committee shall be empowered to prescribe its rules of operation which shall not be in conflict with the policies or By-Laws of the Association. The committee shall also encourage and assist component medical societies in forming Committees on Peer Review at the local level.

Section 4. Committee on Publications. The Committee on Publications shall consist of six members. These shall consist of the Editor, the two Associate Editors, and three others, the three latter being appointed by the Board of Trustees for terms of three years which are so arranged to provide for appointment of one such member annually. The chairman of the committee shall be designated by the Board. The committee shall implement instructions and policies of the Board of Trustees relating to the official JOURNAL of the Association. Additionally, the committee shall study and recommend to the Board policy proposals relating to organization and production of the JOURNAL, reporting annually its deliberations.

Section 5. Committee on Medicine and Religion. The Committee on Medicine and Religion shall consist of six members appointed for terms of three years each and so arranged to provide for appointment of two members annually. The committee shall be responsible for formulating a program in the field of medicine and religion and for carrying out such assignments as may be made in this connection by the Board of Trustees.

Section 6. Committee on Long-Range Planning. The Committee on Long-Range Planning shall consist of five members appointed for terms of five years each and so arranged to provide for appointment of one member annually. This committee shall receive charges from the Board of Trustees and shall assess developments and requirements in fields of association activity, making recommendations for courses of action to achieve maximum possible effectiveness in all fields of association activity.

Chapter XI
RULES AND CONDUCT

The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

Chapter XII
COMPONENT SOCIETIES

Section 1. Component Societies. All component societies now in affiliation with this Association or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall, upon application to the Board of Trustees and approval by the House of Delegates, receive a charter from and become a component part of this Association. The Board of Trustees and House of Delegates, on recommendation by the Judicial Council, shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and By-Laws.

Section 2. Number of Societies. Only one component medical society shall be chartered in any county but nothing in this section shall be construed as to prohibit unofficial organization of medical clubs or other county level groups of physicians whose purpose it is to further and advance scientific medicine and postgraduate medical education.

Section 3. Members of Societies. Each component society shall judge the qualifications of its own members, but as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who is qualified under Chapter I, Section 1, of these By-Laws shall be eligible for election to membership. Before a charter is issued to any component society, full and ample opportunity shall be given to every such physician in the county to become a member.

Section 4. Right of Appeal. Any physician who may feel aggrieved by the action of the society of his county or District in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Judicial Council, which, upon a majority vote, may permit him to petition for membership in an adjacent society.

Section 5. Evidence of Appeals. In hearing appeals, the Judicial Council may admit oral or written evidence, as in its judgment will best and most fairly present the facts, but

in case of every appeal, efforts at a conciliation and compromise shall precede all such hearings.

Section 6. Area Jurisdiction. A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he resides.

Section 7. Professional Authority. Each component society shall have general direction of the affairs of the profession in its jurisdiction and shall constantly use its influence to the moral and professional betterment of its physicians, to the end that the membership shall embrace every qualified physician in its jurisdiction.

Section 8. Meetings. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall especially be encouraged to do postgraduate work, and to give the society first benefit of such labors. Official positions and other preferments shall be unstintingly given to such members.

Section 9. Delegates. Each county shall be entitled to representation in the House of Delegates of this Association, one delegate for each fifty members or fraction thereof. Delegates shall be elected for terms of not less than two years and societies shall report such elections to the Executive Secretary of the Association in no event later than thirty days before the annual session.

Section 10. Duties of Component Society Secretaries. The secretary of each component medical society shall perform such duties as are usual and customary to his office. He shall maintain the official roll of membership for his society, shall collect dues and assessments, and shall make official reports as elsewhere prescribed in these By-Laws to the Association, transmitting dues in behalf of component society members. He shall conduct the official correspondence of his component medical society.

Chapter XIII
FISCAL YEAR

The fiscal year of the Association and its component county societies shall begin January 1 each year and end on December 31 following, but membership in the state Association shall not lapse until April 1 of that year.

Chapter XIV
AMENDMENTS

These By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, after the amendment has laid upon the table for one day.

Chapter XV
REPEALING AUTHORITY

Upon adoption of these By-Laws, all previous By-Laws, motions of record, mandates, policies, rules and regulations in conflict therewith are hereby repealed, except that officers elected to serve in the Association and its component societies shall continue their incumbency until the completion of their previously prescribed terms and their successors elected under the current By-Laws.

AMERICANS WORK FOUR MONTHS JUST TO PAY TAXES

The average worker pays in federal, social security, state and local taxes an amount equivalent to their earnings for the months of January, February, March and April. The Tax Foundation calculates that in an eight hour shift, 2 hours and 39 minutes of work are required to pay taxes. Despite the recent income tax cut this figure has increased 4 minutes over last year. Taxes are by far the biggest single item in the family budget. An eight hour workday breaks down as follows:

To Pay For . . .	You Work . . .
Taxes	*2 hours 39 minutes*
Food	1 hour 5 minutes
Housing	1 hour 32 minutes
Clothing	29 minutes
Transportation	39 minutes
Medical Care	*25 minutes*
Recreation	19 minutes
All Other	52 minutes



The President Speaking

"The AMA Meeting in Dallas"

LYNE S. GAMBLE, M.D.
Greenville, Mississippi

On Wednesday, June 30, 1976, during the annual convention of the American Medical Association in Dallas, it was my privilege to represent the Mississippi State Medical Association at the inauguration of Richard E. Palmer, M.D., as the 131st president of the American Medical Association. Dr. Palmer is a pathologist at the Alexandria Hospital in Alexandria, Virginia. Among numerous other responsible positions, he is on the Executive Committee of the American Board of Pathology. Following his inauguration, Dr. Palmer addressed the House of Delegates. I found particularly interesting his points that: "The federal government has become the chief arbiter of what is desirable and what is possible. It is far less adept in realizing possibilities, however, than in stimulating desires. Some group has to be blamed and disciplined for the embarrassing gap, and in medical care, that group is the givers of care." And "you and I and our fellow physicians find ourselves assailed because the principles, and dynamics, and the inescapable costs of medical science cannot easily be accommodated to political whims and will-o'-the-wisps."

The AMA Council on Medical Service presented an extensive report concerning the effect of Medicare and Medicaid reimbursement policies on the distribution of physicians. The report resulted from a resolution adopted at last year's AMA meeting which was supported by our association. The council concluded that sufficient discrepancies existed between rural and urban fees . . . "to merit serious efforts at relief." Although the solutions recommended by the council and adopted by the House of Delegates were not to the satisfaction of all states including Mississippi, our AMA has finally gone on record to recognize a problem that has plagued rural states for many years. The solutions were to (1) emphasize UCR as the basis for physician payment; (2) urge physicians to bill their usual fee even if payors reduce the amount of payment; and (3) seek repeal of the Medicare "economic index." Parenthetically, it should be noted, too, that there is a bill (S.3205) before Congress which specifically proposes solutions to rural-urban fee discrepancies.

A resolution adopted at our recent MSMA House of Delegates meeting and concerning a nationwide but state operated medical injury compensation plan similar to the present Workmen's Compensation Plan was referred to Reference Committee H. The resolution was warmly received and thoroughly discussed. It was my privilege to speak in support of the resolution. The recommendation of the reference committee to the House of Delegates that the

(Continued on page 254)

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XVII, NUMBER 8
AUGUST 1976

EDITORIALS

Position Paper on Mammographic Examinations

Editor's Note: The American College of Radiology has asked that the following statement on mammographic examinations and their proven value in detecting early breast cancer be published.

The ACR Commission on Cancer and its Committee on Mammography and Diseases of the Breast have completed this policy statement after many months of study. The statement is presented to emphasize that mammographic examinations are valuable and absolutely essential, according to the college. The statement, prepared by medical experts in x-ray diagnosis, is issued in the wake of criticism that has appeared in newspapers and magazines throughout the United States and Canada.

Myron W. Lockey, M.D.
Associate Editor
Jackson, MS

American College of Radiology
Commission on Cancer
Interim Statement
On Breast Cancer Diagnosis

I. INTRODUCTION

Mammography has proven to be the most effective diagnostic tool so far developed for the detection of breast cancer at an early stage before it spreads to regional lymph nodes. This early detection increases the probability of cure. Mammography at appropriate intervals in asymptomatic women over age 35 promises to reduce significantly the number of deaths from breast cancer.

Since there is now no definitive scientific evidence with regard to:

1. optimal age for the initial mammogram;
2. frequency of examination;
3. data on possible long term radiation risk;

this statement is being issued, as a summary of current informed opinion.

II. CARE OF WOMEN WITH SYMPTOMS

In women who have symptoms or physical findings suggestive of possible breast cancer, medical decisions must be individualized to fit the patient's needs. Under these circumstances, mammography is an integral part of the evaluation of the patient.

III. SCREENING OF ASYMPTOMATIC WOMEN

Recognizing that definitive data are not yet available that allow the establishment of firm criteria that define a protocol for the screening for breast cancer in asymptomatic women, the ACR recommends the following:

1. All women should have annual physical examination of the breasts and be taught breast self-examination.
2. For asymptomatic women the first, or baseline, mammographic examination should be performed between the ages of 35 and 40.
3. Subsequent mammographic examinations should be performed at one to three year intervals unless more frequent examination is medically warranted.
4. After age 50, annual or other regular interval examinations, including mammography, should be performed.

5. Although the carcinogenic effects of radiation at current levels of exposure are probably immeasurably small, continuing attempts to reduce exposure should be made. However, image quality must be preserved for accurate diagnosis to insure the best risk/benefit (cure) ratio.

6. Each radiologist should assure the periodic monitoring of his equipment and procedures to determine that the patient's exposure is being maintained at the lowest feasible level.

IV. RESEARCH PROGRAMS

The protocol currently being followed by the NCI/ACS sponsored "Breast Cancer Detection Demonstration Projects" should be pursued so that the data are as complete and accurate as possible in order that meaningful conclusions can be drawn. Follow-up of the patients must be carried out for a number of years to insure collection and evaluation of the data. Theoretical concerns of possible radiation induced breast cancer do not warrant change in the current protocol of the "Breast Cancer Detection Demonstration Projects." Estimates of risk that include a radiation carcinogenic effect are of dubious validity because of the lack of objective scientific evidence.

Research must be continued and encouraged to:

1. improve methods for measurement of low level radiation;
2. further reduce the radiation dose in mammography consistent with good image quality;
3. determine the most appropriate age at which to begin screening for different risk groups;
4. define women of high risk;
5. define those mammographic findings that dictate re-examination at a shorter interval;
6. establish the appropriate intervals for re-examination; and
7. collect evidence of the benefits and risks of mammography.

V. FUTURE STATEMENTS

Further statements will be issued when additional valid information permits.

The President Speaking

(Continued)

resolution be referred to the Board of Trustees for further study with the report to be submitted at the 1976 Clinical Convention was adopted by the House of Delegates. A statement was made at the meeting of Reference Committee H by the president of the Canadian Medical Association to the effect that the heretofore stable professional liability situation in Canada was deteriorating.

With appropriate formality, including an address and the presentation of albums by Mr. Paul N. Carlin, Assistant Postmaster General of the United States, the first Day of Issue ceremony of a Bicentennial Envelope honoring the role of the American Doctor in the Bicentennial Era was carried out. These envelopes postmarked Dallas, TX, June 30, 1976, FIRST DAY OF ISSUE were available to us.

I came away from the annual meeting of our American Medical Association impressed by both the breadth and scope of activities our profession is concerned with and the democratic manner in which our AMA House of Delegates responds. ★★★

Medico-Legal Briefs

PATIENT MUST ARBITRATE CLAIM OF NEGLIGENCE

A patient who signed an agreement to arbitrate all money claims against a hospital was bound to arbitrate a negligence claim against the hospital, a California appellate court ruled.

Acting on her physician's instructions, the patient had checked into the hospital for surgery. One of the forms the admission staff had her fill out was an agreement binding the patient and the hospital to settle claims for money damages by means of arbitration.

Four months after surgery, the patient filed a malpractice suit against the hospital and her physician. The hospital notified her of the arbitration agreement, and she repudiated it. After a hearing, the trial court said the compulsory arbitration agreement violated public policy. The hospital appealed.

Reversing the trial court's decision, the California appellate court said that it could find no authority for holding that the contract violated public policy. The patient's failure to read or understand the arbitration clause was not a defense. There was no evidence that the patient was misled, and the terms of the agreement were clear and unmistakable, the court said. Nor was there evidence that the hospital exerted undue influence or coercion, the court added.

Arbitration can be a favored means of resolving controversies. The appellate court took judicial notice of the growing acceptance of the use of arbitra-

tion to settle medical malpractice claims. The arbitration clause was not so ambiguous or beyond reasonable expectations of the patient as to be treated as an adhesion contract and interpreted in favor of the patient, the court said. An adhesion contract would be a one-sided arrangement presented on a "take it or leave it" basis.

Finally, the court felt it was irrelevant that the patient had to arbitrate her claim against the hospital but had to proceed against the physician in court. The trial court's decision was reversed, and the dispute was remanded for arbitration.—*Burton v. Mt. Helix General Hospital,* 127 Cal.Rptr. 791 (Cal.Ct. of App., Feb. 24, 1976)

NEW MEMBERS

BRANTLEY, TERRY K., Jackson. Born Laurel, MS., Nov. 28, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1970; interned Mississippi Baptist Hospital, Jackson, one year; Residency (Ob-Gyn), same, Sept. 1973-Jan. 1975; elected by Central Medical Society.

DALE, ROBERT A., Jackson. Born Star City, AK, Mar. 23, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1974; Residency (Ob-Gyn) July 1974-Dec. 1975; elected by Central Medical Society.

FLECKENSTEIN, LOREN D., Meridian. Born Meridian, MS, Sept. 5, 1944; M.D., University of Kansas, Kansas City, 1965; interned Kansas City General Hospital, Kansas City, MO, one year; Residency (Surg) University of Tennessee, Memphis, 1966-67; Residency (Neuro-Surg), same, 1967-1971; elected by East Mississippi Medical Society.

DILWORTH, ROBERT EARLE, Meridian. Born Shreveport, LA, Aug. 1, 1944; M.D., Louisiana State University School of Medicine, New Orleans, 1970; interned Confederate Memorial Medical Center, one year; Residency (Urology), same, 1971-75; elected by East Mississippi Medical Society.

HUDSON, STARKEY L., Jackson. Born Webb, MS, Mar. 21, 1941; M.D., Howard University College of Medicine, Washington, DC, 1970; interned Freedmen's Hospital, Washington, DC, one year; elected by Central Medical Society.

KINSEY, HERBERT P., Lucedale. Born Mobile, AL, Dec. 6, 1935; M.D., University of Alabama School of Medicine, Birmingham, 1959; interned St. Vincent Hospital, Birmingham, AL, one year; Residency (Surg) Lloyd Nolan Hospital, Fairfield, AL, 1960-64; elected by South Mississippi Medical Society.

MCILWAIN, JAMES S., JR., Clinton. Born Jackson, MS, April 3, 1942; M.D., University of Mississippi School of Medicine, Jackson, 1967; interned Medical Center, Columbus, GA, one year; elected by Central Medical Society.

SWANTON, JOSEPH E., Mound Bayou. Born Gorham, ME, Jan. 5, 1929; M.D., University of North Carolina School of Medicine, Chapel Hill, NC, 1960; interned North Carolina Memorial Hospital, Chapel Hill, one year; Residency (Ob-Gyn), same, 1961-62; Residency (Ob-Gyn), Temple University Hospital, Philadelphia, PA, 1967-68; Residency (Ob-Gyn), New Hanover Memorial Hospital, Wilmington, NC, 1969-70; elected by Delta Medical Society.

TIPTON, A. C., JR., Jackson. Born Natchez, MS, 1939; M.D., University of Mississippi School of Medicine, Jackson, 1965; interned Union Memorial Hospital, Baltimore, MD, one year; Residency (Neurology), UMC, 1966-69; Fellowship, Ann Arbor, MI, 1969-70; elected by Central Medical Society.

WATKINS, CHARLES, Gulfport. Born Shaw, MS, Jan. 9, 1916; M.D., University of Tennessee School of Medicine, Memphis, TN, 1938; interned DePaul Hospital, St. Louis, Mo., one year; Residency (Psy), St. Lawrence State Hospital, Ogdensburg, NY, one year; Residency (Psy), Duke Hospital, Durham, NC, 1946-48; elected by Coast Counties Medical Society.

DEATHS

BROWN, WILLIAM A., JR., Mathiston. Born Wildsville, LA, July 17, 1930; M.D., University of Mississippi School of Medicine, Jackson, 1957; interned Baptist Hospital, Little Rock, AR, one year; died July 3, 1976, age 45.

ELLIS, CLYDE A., Clarksdale. Born Lambert, MS, Mar. 25, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned Mississippi Baptist Hospital, one year; Residency (Rad), UMC, Jackson, 1970-73; died June 16, 1976, age 32.

DEATHS / Continued

MASON, GEORGE S., Yazoo City. Born Clara, MS, June 9, 1913; M.D., Tulane University School of Medicine, New Orleans, 1939; interned Southern Pacific Hospital, Houston, TX, one year; died May 2, 1976. age 62.

HAMRICK, DEWITT, Corinth. Born Meridian, MS, Sept. 4, 1899; M.D., University of Virginia School of Medicine, Charlottesville, VA, 1926; interned, same, one year; died June 19, 1976, age 76.

PERSONALS

JERRY R. ADKINS and RAY L. WESSON of The Surgical Clinic of Biloxi, P.A. announce the relocation of their office to the Medical Plaza Building, 127 Lameuse Street, Biloxi.

OSCAR J. BRISENO has set up practice in Bay Springs in the new clinic building across the street from the Jasper General Hospital.

JOHN BYARLAY of Corinth has closed his practice. WILLIAM JACKSON will be assuming Dr. Byarlay's practice in September.

WILLIAM W. BRADFORD has associated with SIDNEY A. CHEVIS of Bay St. Louis for the practice of family medicine at 644 Dunbar Avenue.

WILLIAM H. C. DUDLEY, JR., announces the opening of his office for the practice of psychiatry at St. Joseph Community Hospital, Hwy. 39 North in Meridian.

JAMES V. FERGUSON, JR., of Greenwood has been elected chairman of the Medical Alumni Guardian Society of The University of Mississippi Foundation.

TOMAS R. FLORES announces the opening of his office for the practice of orthopedic surgery at the Magnolia Doctors' Plaza, Suite 105, in Corinth.

BEDFORD F. FLOYD of Gulfport announces that he retired from practice on July 1. Dr. Floyd and W. F. MCDONNELL were honored on their retirement from the medical staff with a reception by Memorial Hospital at Gulfport and the medical staff.

W. G. GILES, J. STEWART WILLIFORD, and THOMAS J. DEWEY of Hattiesburg announce the relocation of their Orthopedic Clinic P.A. to No. 7 Medical Boulevard.

WILLIAM L. HAND has associated with The Meridian Orthopedic Clinic P.A. at 1103 21st Avenue in Meridian for the practice of orthopedic surgery.

CALEB W. HERNDON has set up his practice in ophthalmology in Brookhaven and is building a new clinic across from King's Daughters Hospital.

CHARLES HOGUE of Yazoo City has been elected to the board of the Mississippi Arts Festival, Inc.

C. M. HUTCHINSON has associated with The Surgery Clinic of Tupelo, P.A. for the practice of surgery at 607 Garfield Street in Tupelo.

FRANK LEGGETT of Bassfield was given a special appreciation award by the Pine Burr Area Council, Boy Scouts of America, for his assistance in giving each boy from the Tall Pines District a physical examination as he entered Camp Taik for the week.

W. H. MERRELL, JR., of Jackson has been promoted to Colonel. Dr. Merrell, a practicing urologist, is a member of the 134th Combat Support Hospital.

FRANCIS MORRISON of Jackson and UMC represented Mississippi at the board meeting of the South Central Association of Blood Banks in Little Rock and at the annual meeting of the Council of Community Centers in Seattle.

JAMES E. STRONG, JR., has associated with CHARLES R. MCCOLLUM of Jackson for the practice of internal medicine at 1815 Hospital Drive, Suite 262.

WALTER TREADWELL of Jackson is the new chairman of the Hinds County chapter Advisory Board of the Mississippi Lung Association. Also serving on the advisory board is J. L. WOFFORD of Jackson.

W. LAMAR WEEMS of Jackson and UMC participated in an American Medical Association bladder cancer symposium in Dallas and addressed the Memphis Urological Society during June.

GEORGE E. WILKERSON of Hattiesburg was guest speaker before the Hattiesburg Kiwanis Club.

CECIL T. WILLIAMS, JR., of Laurel received the Bronze Distinguished Service Award at the Mississippi Heart Association's 25th annual assembly in Jackson for planning the annual meeting.

The Radiological Group, P.A. of Jackson announces the association of ALLEN R. YATES in the practice of radiology at 316 Medical Arts Building and at the Mississippi Baptist Medical Center.

MSMA Council on Scientific Assembly Begins Planning 1977 Annual Session

The MSMA Council on Scientific Assembly held its planning meeting for the 1977 annual session on July 11 at the Sheraton-Biloxi, site of the 109th Annual Session set for May 2-5, 1977.

Dr. Elmer Nix of Jackson, council chairman and Secretary-Treasurer of the association, presided over the meeting which included representatives from ten of the twelve scientific sections making up the council.

The council voted to follow the same general format with space to be allotted on the program for the three new sections which were approved by the House of Delegates this past May.

The schedule for the 1977 scientific meetings is: Sunday afternoon, May 1—Sections on Psychiatry, Anesthesiology and Pathology; Tuesday morning, May 3—Sections on Dermatology and Medicine; Tuesday afternoon—Sections on Surgery, Pediatrics and Radiology; Wednesday morning, May 4—Sections on EENT and Family Practice; and Wednesday afternoon—Sections on Ob-Gyn and Preventive Medicine. The House of Delegates will meet on Monday and Thursday mornings. Monday afternoon has been reserved for meetings of the reference committees and the Mississippi Foundation for Medical Care.



The Council on Scientific Assembly has begun planning for the 109th Annual Session of the association.

Following the usual procedure, letters of invitation with the 1977 scientific meeting schedule will be sent to specialty societies in the state who wish to hold concurrent meetings.

The council also voted that the association will pay expenses for one out of state speaker per section for the 1977 meeting. Dr. Nix noted that sections are free to find outside funding for another out of state speaker, if desired.

It was decided that the association would not sponsor the annual dinner party with entertainment but that a cocktail party would be planned for Tuesday night, May 3. This was done so that MSMA members could enjoy a fellowship occasion before dining out at the coast's many excellent seafood restaurants, said Dr. Nix.

Noting that the Sheraton now has four tennis courts, the council voted that a mixed doubles tennis tournament be held during the 1977 annual session.

The council also voted to continue support of the Sunday afternoon welcome booth which has been planned and staffed by Auxiliary members for the past three years.

It was decided that scientific exhibits would be accepted on a first come, first served, basis again in 1977. Invitations to present exhibits will be published in the JOURNAL MSMA and the Blue Sheet, said Dr. Nix.

A deadline of December 31, 1976, was set for all completed scientific section programs to be received in the headquarters office. Members desiring to be considered as speakers are urged to contact the Council on Scientific Assembly secretary at the headquarters office as soon as possible.

HSA Protest Is Filed

In a strongly worded letter, MSMA President Dr. Lyne S. Gamble of Greenville has formally voiced the association's protest about the conduct of the Mississippi Health Systems Agency, Inc. in organizing as Mississippi's Health System Agency under requirements of Public Law 93-641.

Citing numerous deficiencies and violations of both federal and state law and its own by-laws, the MSMA protest called on Secretary of H.E.W. Mathews to not designate Mississippi Health Systems Agency, Inc. . . . "as Mississippi's HSA, thus alleviating the need for other remedial action. . . ."

The association's protest grew out of an action of the House of Delegates at the recent annual session where after some two hours of discussion the delegates went on record ". . . against the discriminatory and arbitrary manner . . ." Mississippi Health Systems Agency, Inc. had implemented Public Law 93-641 in Mississippi.

The protest outlined and documented instances of abuse in the MHSA, Inc. notification and election process to include such things as selective notice to certain groups, voting by non-residents and vote manipulation. Further cited were the activities of the MHSA, Inc. president who worked for a "special interest" group while he formulated the MHSA, Inc. application.

The MHSA, Inc. application was further criticized for its ". . . uninspiring work program and shallow understanding of the health care needs and priorities of the people of Mississippi."

MSMA has also requested the Secretary of H.E.W. to designate three or more Health Systems Areas in Mississippi based on hindsight from watching activities in a Statewide Health Systems Area.

MSMA Stresses CME

The association's newly expanded Council on Medical Education is stressing continuing medical education accreditation and documentation to physicians in Mississippi this year.

The council, which was recognized by the AMA Council on Medical Education beginning in 1974 as an accrediting body for intrastate CME programs, is encouraging hospitals and medical organizations to seek accreditation of their CME programs for physicians. The programs must be organized on a continual basis and address identified needs in order to meet accreditation requirements. Several Mississippi hospitals and medical organizations have already been accredited by the council.

Accreditation means the hospital's or organization's CME programs for physicians provide prescribed hours for the AMA "Physician's Recognition Award" for all physicians. Often times accreditation can also mean a CME program meets hours prescribed by the American Academy of Family Physicians for its members.

In a further effort to encourage CME the council last month notified all MSMA members that the association's office would begin keeping records of CME attendance reported by the members for annual reporting to the individual member.

CME is now a requirement for annual renewal of physicians' licenses in nine states. Fifteen state medical associations now require CME as a condition of membership and the MSMA House of Delegates recently directed the Council on Medical Education to bring in a plan for CME as a condition for membership in the association.

Information concerning all aspects of the council's CME accreditation program can be obtained by calling or writing the MSMA office.

The council was expanded from three to nine members at the recent annual session and the following physicians now serve: Carl G. Evers, Jackson, chairman; Whitman B. Johnson, Jr., Clarksdale; M. Beckett Howorth, Jr., Oxford; David V. Ellis, New Albany; James E. Booth, Eupora; William M. Hilbun, Jr., Meridian; W. Boyce White, Laurel; William E. Godfrey, II, Natchez; and Karl B. Horn, Moss Point.

Most UMC House Staff Are From In-State

Forty-three of the 62 first-year house officers at the University of Mississippi Medical Center are Mississippi medical school graduates.

The out-of-state graduates came to UMC from nearby medical schools in Alabama, Louisiana, and Tennessee as well as from Arizona, Nebraska, Ohio, and Pennsylvania.

Thirty-one per cent of the new house officers are in internal medicine training programs. Family medicine got the second largest number, 12, and surgery and pediatrics took eight officers each.

Remaining physicians are in obstetrics-gynecology, anesthesiology, pathology, radiology, neurology, and flexible programs.

They join other physicians in the second through seventh postgraduate years to give UMC a total of 271 house officers.

Dr. L. G. Hopkins Is New MHA President

Dr. Lloyd Gerald Hopkins of Oxford has been installed as president of the Mississippi Heart Association. He is a practicing physician, a farmer, and an instructor in the Ole Miss School of Pharmacy.



Dr. Hopkins

Dr. Hopkins was elected at the association's 25th Annual Meeting in Jackson.

A volunteer with the Heart Association for many years, he has served as chairman of District Five, and as secretary, vice president and president-elect of the Mississippi Heart Association. On major committees, he has been concerned with research, high blood pressure and public education.

A native of Oxford, Dr. Hopkins received his medical degree at the University of Mississippi and interned at City of Memphis Hospitals. He is a member of the Mississippi Cattleman's Association, and serves on the Board of Trustees of Oxford Lafayette County Hospital, College Hill Academy and Oxford Bank and Trust Company. Additionally, Dr. Hopkins is serving as vice chairman of the State Board of Mental Health and as team physician to the Ole Miss football team.

He is married to the former Mildred Douglass and they are the parents of three children, Holly, Heidi and Lloyd Gerald Hopkins, Jr.

Other MHA officers elected were: state senator W. B. Alexander of Cleveland, president-elect; UMC asst. prof. of surgery, Dr. Patricia C. Moynihan, vice president; retired executive officer of MFC Services, Ernest G. Spivey of Jackson, treasurer; and insurance executive, Preston Gough of Jackson, assistant treasurer.

Health Manpower Bill Passes

The so-called Health Manpower Bill which will evolve out of Congress this year with controls on residencies and "payback or service" requirements should not have a dramatic impact on the University of Mississippi School of Medicine.

After deletion of many adverse provisions, the bill expected to pass will require medical schools which receive federal aid to have an increasing percentage of residents in the "primary care" specialties. The maximum percentage mentioned has been 57 per cent by 1979. UMC is near that percentage at this time and the number of students entering "primary care" specialties has been increasing each year.

The "payback or service" requirements are expected to be in the form of linking federal capitation aid to schools with service in shortage areas or financial payback to the federal government and expanded federal loan assistance. The latter will require medical schools to accept an increasing number of medical students who are seeking and willing to accept financial assistance in return for practicing in a medically underserved area for a few years after they graduate. Again, both the state of Mississippi and the UMC have for many years supported and sought medical loan funds based on repayment of such funds by service in the state's medically underserved areas. A big problem has been getting sufficient monies for students seeking such aid.

Mississippi Professional Liability Premiums Rise

St. Paul Insurance Company, the major underwriter of physicians' professional liability insurance in Mississippi, has filed and received approval from the Mississippi Insurance Commission for rate increases amounting in some cases to 100 per cent of last year's premiums.

The new rates which become effective for policies sold or renewed this year range from $276 to $1931 on renewed policies and $181 to $1,156 on new policies for basic $100,000/300,000 policy limits. Excess coverage rates remain at 100 per cent of the basic rate. This means that physicians in the highest rate/premium class will be paying some $4,000 for basic and excess limits coverage. Last year the same physicians paid some $2,300 for coverage.

St. Paul, which now insures over 1,400 Mississippi physicians, has also implemented a new rating clas-

sification system containing seven classes instead of the old five class system. Physicians specializing in vascular, neurological, orthopaedic, cardiovascular and thoracic surgery are in the highest class.

In announcing the new rates, St. Paul projected a continuing increase in claims based on present trends. In 1975 there were 83 claims reported compared to some 60 claims in 1974.

UMC's First Family Practice Residents Finish

Mississippi's first state-trained family medicine specialists completed residency requirements this summer at the University of Mississippi Medical Center.

The four, Dr. Phillip Balaski, Dr. John Hassell, Dr. Deirdré Phillips, and Dr. Edwin Searcy, will all live and practice in Mississippi. Each will participate in a general group practice to give comprehensive care to Mississippi families.

"Specialty training for general practice really isn't the contradiction it seems," said Dr. Searcy, whose father was a Cleveland general practitioner.

The good GP always recognized the special nature of his work and put in many independent hours of study to provide the diversity of care his "general" practice demanded, he pointed out.

It was only in 1970 that medical schools began offering specialty training in family medicine, and growth has been rapid. The new UMC program could take only four residents when the first group entered in 1973. Today, 12 residency slots are available each year, making the Medical Center program one of the largest in the nation.



The first physicians to complete the University of Mississippi Medical Center three-year residency in family medicine will live and practice in Mississippi. They are, from left, Dr. Edwin Searcy of Cleveland, Dr. Phillip Balaski of Picayune, Dr. John Hassell of Moss Point, and Dr. Deirdré Phillips of Tangipahoa, La.

At the Medical Center, family medicine is the third largest specialty field. Five residents are currently in third year training, 11 in second, and 12 in first at UMC.

First year residents rotate through internal medicine, pediatrics, obstetrics-gynecology, surgery, the emergency room, and family medicine at University Hospital.

In the second year, under faculty supervision, they assume full responsibility for the care of patients in a model practice clinic. They study with specialists to sharpen referral skills.

Third year residents get still more experience in a model practice clinic, in hospitals at Vicksburg, Pascagoula, and Whitfield, and with private practitioners in a variety of locations.

"Family practitioners don't pretend to have all the answers," Dr. Phillips said. "Our goal is to give our patients the best possible care, whether we do it ourselves or refer."

UMC Receives Mississippi Chemical Grant

A $35,000 grant from Mississippi Chemical Corporation to the University of Mississippi Medical Center will help support family physician residency training over a three-year period.



University of Mississippi Medical Center Vice Chancellor Dr. Norman C. Nelson, right, accepts a $35,000 grant to the UMC family medicine residency training program from Mississippi Chemical Corporation board president Leroy Percy of Greenville, left, and corporation president Tom C. Parry of Yazoo City. The award is the first of its kind to the Medical Center from a state industry.

Corporation board president Leroy Percy of Greenville, corporation president Tom C. Parry of Yazoo City, and University Chancellor Porter L. Fortune, Jr., jointly announced the award to the University Foundation.

"Mississippi Chemical Corporation has made a major contribution to improving our state's quality of life by boosting farm income and food produce," said UMC Vice Chancellor Dr. Norman C. Nelson, "so it is appropriate that this corporation is the first Mississippi industry to support a Medical Center educational program in this manner.

"This award is an investment in the future health care delivery in our state and tangible evidence of Mississippi Chemical Corporation's keen awareness of the state's critical need for more family physicians," Dr. Nelson said. "With this grant, Mississippi Chemical has again demonstrated its deep concern for our state—and all Mississippians."

Dr. Nelson said the Mississippi Chemical grant to the Medical Center will provide the stipend for a family medicine resident throughout the three-year training period for the specialty.

Twelve new physicians enter UMC family medicine residency training each year. With some 28 currently enrolled, the 1973-established program is one of the nation's largest.

THE LITTLE CARD THAT'S WORTH $2,000 INSTANT CASH, ANY TIME YOU NEED IT.



Give yourself the security, convenience and emergency protection of one of the world's most exclusive financial services—the American Express Executive Card.

Available at Jackson's warm, friendly, little bank, Fidelity Bank. We also honor Master Charge and BankAmericard.

Fidelity Bank
UTICA/JACKSON, MISSISSIPPI
MEMBER FDIC

Index to Advertisers

Blue Cross and Blue Shield of MS	18
Burroughs Wellcome Co.	12
Canton Exchange Bank	15
Coca-Cola	14
Family Practice Physicians Needed	14
Fidelity Bank	19
Hill Crest Hospital	16
Hyrex-Key Pharmaceuticals	7
Key Pharmaceuticals, Inc.	17
Eli Lilly and Co.	front cover
Mead Johnson Laboratories	8
Merck Sharp and Dohme	228F, 228G, 228H
Pennwalt Prescription Products	242B, 242C, 242D
Pharmaceutical Manufacturers Assoc.	10B, 11
Premier Printing Co.	15
Roche Laboratories	second cover, 3, 228D, 228E, third and fourth covers
Roerig and Co.	228A
Smith Kline and French	228B
Southern Medical Association	6
The Upjohn Co.	228C
Warner-Chilcott Laboratories	10, 10A
Thomas Yates and Co.	4

IN CONCLUSION

The AMA will participate in HEW's new "fraud and abuse initiative" program to crack down on the "dishonest activities of some Medicaid providers and clear the image of the overwhelming majority who are honest." C. W. Camalier, M.D., chairman of the AMA's Council on Medical Services, said the AMA was enthusiastic about the HEW effort because "we, too, are convinced that a very small minority of Medicaid providers are actually engaged in fraudulent or abusive practices. "AMA Ad hoc Committee on Medical Discipline may offer suggestions.

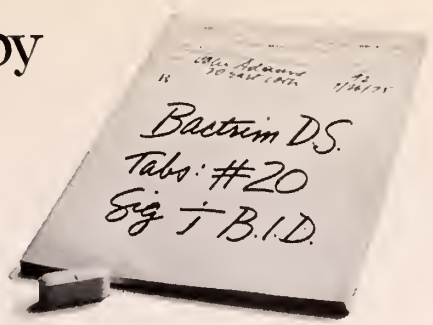
The newly organized American College of International Physicians, Inc. composed of licensed practicing physicians who are graduates of medical schools outside of the U.S., will hold its first annual convention, scientific session, and convocation of fellows, in Chicago, on Oct. 16-17. The new college was recently incorporated as a nonprofit, tax-exempt corporation, and is devoted to the international physician's education and continuing advancement of his skills in medicine. For further information write the College at Suite 12, 3030 Lake Avenue, Fort Wayne, IN 46805.

"To blame the drug industry for prescribed-drug addiction is as irrelevant as blaming the Mafia for the use of illicit drugs. The current pattern of overconsumption of drugs -- be they effective remedy or anodyne; prescription item or part of everyday diet; free, for sale or stolen -- can be explained only by people's belief that in health care, as in all other fields of endeavor, technology can be used to change the human condition according to almost any design. Penicillin and DDT, consequently, are viewed as the hors d'oeuvres preceding an era of free lunches," says Ivan Illich.

National Association of Insurance Commissioners has released the second of four volumes of its closed-claim survey on medical injury cases. According to the survey, the 10 leading states in terms of numbers of medical injury allegations made are: California, New York, Pennsylvania, Illinois, Florida, Michigan, Ohio, Texas, Maryland and Alabama. Least number experienced was in Alaska. Hospital-based claims accounted for 80% of incidents and 84% of payout. Highest awards were made for those injuries arising out of obstetrical procedures.

A successful countersuit by an Illinois physician against a patient and the attorneys who had charged him with malpractice was termed "significant" by AMA president Max H. Parrott, M.D., "because it serves notice that doctors intend to fight back against non-meritorious cases and puts lawyers on notice that they are placing themselves in jeopardy if they do not adequately investigate a case before filing it." If the case stands up on appeal, Dr. Parrott said, it should have "a beneficial effect on the professional liability situation in the long run."

10-day Bactrim therapy outperforms 10-day ampicillin therapy.

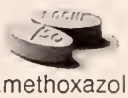


In a multicenter, double-blind study of patients with chronic or frequently recurrent urinary tract infection, Bactrim 10-day therapy outperformed ampicillin 10-day therapy by 27.2%, when comparing patients who maintained clear cultures for eight weeks. Criterion for "clear culture" was 1000 or fewer organisms/ml of urine.

While adverse reactions noted in this study were mild (*e.g.*, vomiting, nausea, rash), more serious reactions can occur with these drugs. See manufacturer's product information for complete listing. Maintain adequate fluid intake; perform frequent CBC's and urinalyses with microscopic examination.

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

Bactrim™ DS
(160 mg trimethoprim and 800 mg sulfamethoxazole)
Double Strength tablets
Just 1 tablet B.I.D.

Bactrim™

(80 mg trimethoprim and 400 mg sulfamethoxazole)
2 tablets B.I.D.

For chronic or frequently recurrent cystitis and pyelonephritis due to susceptible organisms.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections evidenced by persistent bacteriuria (symptomatic or asymptomatic), frequently recurrent infections (relapse or reinfection), or infections associated with urinary tract complications, such as obstruction. Primarily for cystitis, pyelonephritis or pyelitis due to susceptible strains of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris* and *Proteus morganii.*

NOTE: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections. The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. **Data are insufficient to recommend use in infants and children under 12.**

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) every 24 hours
Below 15	Use not recommended

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole — bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; fruit-licorice flavored — bottles of 16 oz (1 pint).

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

In a multicenter study of patients with chronic or frequently recurrent urinary tract infections

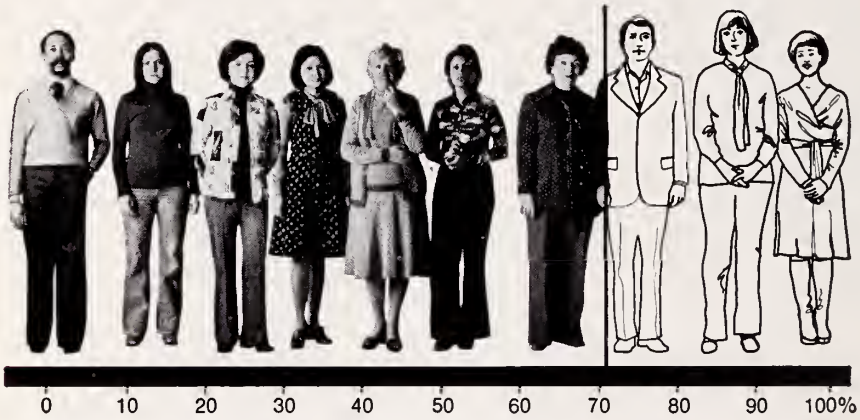
Bactrim was 27.2%* more effective than ampicillin in keeping patients infection-free for 8 weeks.†

N.Y. ACADEMY OF MED
2EAST 103RD ST
NEW YORK N.Y. 10029

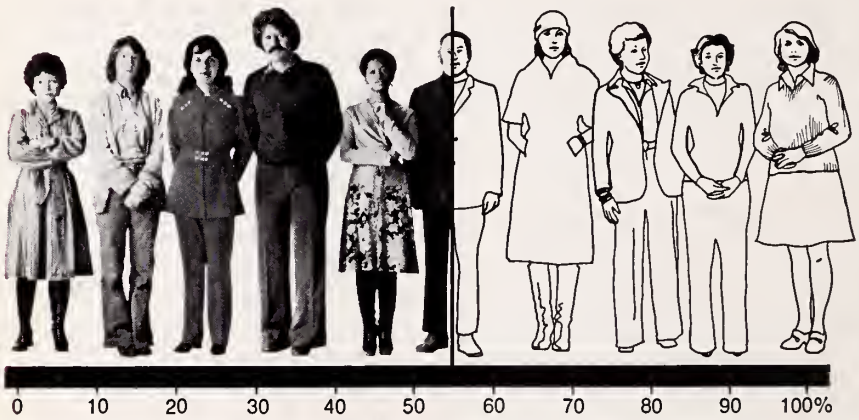
LIBRARY

AUG 18 1976

NEW YORK ACADEMY
OF MEDICINE



Bactrim–70.5% of 78 patients infection-free at 8 weeks.



ampicillin–55.4% of 74 patients infection-free at 8 weeks.

*This percentage is arrived at by the statistical method of dividing the difference between Bactrim and ampicillin results (15.1%) by the percent of ampicillin results (55.4%).

†Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110

Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

Double Strength tablets Just 1 tablet B.I.D.

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

Please see summary of product information on preceding page.

ROCHE

BALCONY

JOURNAL OF THE Mississippi STATE MEDICAL ASSOCIATION

SEPTEMBER 1976

AMERICAN REVOLUTION BICENTENNIAL 1776-1976

New from Lilly/Dista Research

NALFON®
fenoprofen calcium
300-mg.* Pulvules®

DISTA
Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

Additional information available to the profession on request.

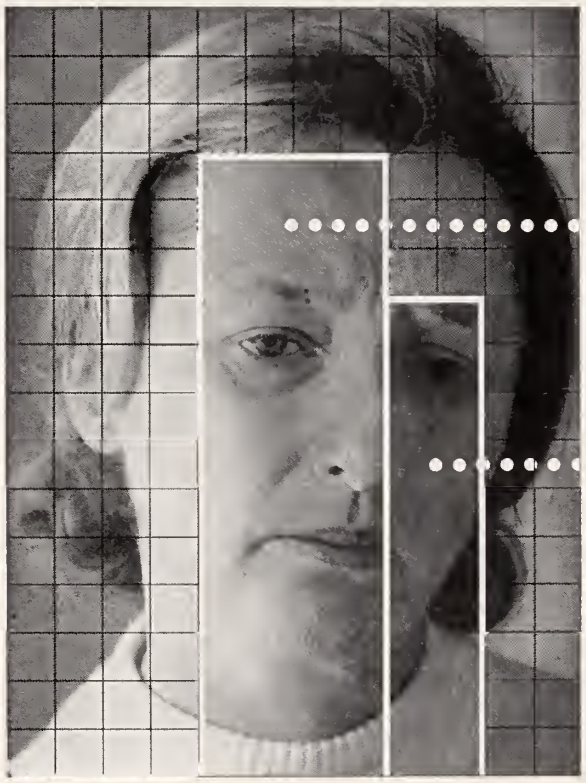
*Present as 345.9 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. fenoprofen.

600091

This Month . . . Maternal and Neonatal Herpes, Incisional Hernia, Liver Scanning, Regional Health Planning

M.S.M.A

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

TO COMPLETE YOUR HEALTH INSURANCE PICTURE, MSMA OFFERS ITS NEW COMPLETE HEALTH INSURANCE PACKAGE:

NEW MAJOR MEDICAL PLAN

Covers 80% of your eligible expenses after you satisfy your deductible amount. Choice of deductibles available. Pays expenses in and out of the hospital!

NEW HOSPITAL MONEY PLAN®

Pays a daily benefit for each day you spend in the hospital because of an accident or illness. Acceptance is GUARANTEED! Pays the benefits directly to *you*!

NEW EXCESS MAJOR MEDICAL PLAN

Picks up where basic insurance programs leave off. Pays 100% of eligible expenses in or out of the hospital—up to $250,000 maximum. And, premiums are LOW! Acceptance is GUARANTEED!

A complete health insurance picture is probably one of the most important items you can provide for your family's financial well-being. To help you combat the rising cost of hospital and medical care, MSMA has entirely revamped its health insurance program to give you the most complete and comprehensive program available . . . and at a low price all can appreciate. Find out more. Mail the coupon below for more information:

THE MSMA INSURANCE PROGRAMS ARE UNDERWRITTEN BY:



CONTINENTAL CASUALTY CO.
ASSOCIATION GROUP DIVISION
Chicago, IL 60685

a division of CNA/insurance

Please send me more details on the NEW MSMA insurance programs:

☐ MSMA MAJOR MEDICAL PLAN ☐ MSMA HOSPITAL MONEY PLAN ☐ MSMA EXCESS MAJOR MEDICAL PLAN

NAME_____

ADDRESS_____

CITY_____

STATE_____ ZIP CODE_____

MAIL TO: Thomas Yates & Co., MSMA Insurance Administrators
P.O. Box 1054, Jackson, Mississippi 39205

Volume XVII
Number 9
September 1976

JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

• EDITOR
W. MONCURE DABNEY, M.D.
• ASSOCIATE EDITORS
GEORGE H. MARTIN, M.D.
MYRON W. LOCKEY, M.D.
• MANAGING EDITOR
NOLA GIBSON
• PUBLICATIONS COMMITTEE
LAWRENCE W. LONG, M.D.
Chairman
ROBERT R. MCGEE, M.D.
T. A. BAINES, M.D.
and the editors
• THE ASSOCIATION
LYNE S. GAMBLE, M.D.
President
JAMES O. GILMORE, M.D.
President-Elect
J. ELMER NIX, M.D.
Secretary-Treasurer
C. D. TAYLOR, JR., M.D.
Speaker
R. FASER TRIPLETT, M.D.
Vice Speaker
CHARLES L. MATHEWS
Executive Secretary
H. CODY HARRELL
Assistant Executive Secretary
WILLIAM F. ROBERTS
Legal Counsel

THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION is owned and published monthly by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, $15.00 per annum; $2 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

CONTENTS

SCIENTIFIC PAPERS

Maternal and Neonatal Herpes Infeetion **261** ROBERT A. DALE, JR., M.D. Jaekson, MS

Problems in Abdominal Surgery V: Ineisional Hernia **266** WILLIAM O. BARNETT, M.D. Jackson, MS

SPECIAL ARTICLES

Radiologieal Seminar CLXII: Liver Seanning in Polycystie Liver Disease **269** JANE A. SANDERS, M.D., and W. MEL FLOWERS, JR., M.D. Jackson, MS

Regional Health Planning: What to Look For **271** Thomas J. Brooks, III Jackson, MS

EDITORIALS

Can We Afford National Health Insuranee? **277** W. MONCURE DABNEY, M.D. Crystal Springs, MS

Editorial Comment on Seientifie Article **278** DONALD M. SHERLINE, M.D. Jackson, MS

THIS MONTH

The President Speaking **275** "Health Care Regulation"

Medieal Organization **285** Board of Trustees Holds Summer Meeting at Pascagoula

Copyright 1976, Mississippi State Medical Association

Most Doctors Would Again Choose Medicine as Career

Despite increasing frustrations, seven out of ten physicians would choose medicine as a career if they had it to do over again, according to a recent poll in the Impact section of *American Medical News*, the American Medical Association's newspaper for physicians.

Two out of ten doctors, however, would not select medicine as a career a second time, and one out of ten isn't sure whether he would or not, the poll found.

Surgeons were least inclined to enter medicine again. Only 30 of 51 respondents said they would do so. Specialists in radiology, internal medicine, psychiatry, pediatrics and obstetrics-gynecology were most likely to repeat their career choice.

Of those who said they would not again choose medicine as a career, the reason most often given is "too much government interference" in medical practice. Others said the working hours are too long, pressures are too great and financial return inadequate for the hours invested and sacrifice demanded.

Those who said they would become physicians again also registered a high degree of satisfaction with their choice of a specialty, more than 80 per cent saying they would again pick the same area. Only 18 per cent would choose another field of practice.

Democratic VP Supported Child-Care, NHI Proposals

Sen. Walter F. Mondale, D-Minn., is better known as a champion of child-care than for his identity with national health insurance, but the Democrats' vice-presidential nominee is a co-sponsor of the Health Security Act (S 3 and HR 21). Mondale became a backer of the Kennedy-Corman plan during the 93rd Congress. He is a member of the health subcommittees of both the Committee on Labor and Public Welfare and the Committee on Finance.

Mondale, a protege of Sen. Hubert H. Humphrey, D-Minn., was appointed to the Senate when Humphrey was elected vice-president in 1964. He won reelection in 1966 and 1972. He was attorney general of Minnesota for four years.

helping you change things for the better

Canton Exchange Bank

A FULL SERVICE BANK

"Your Account Handled in Strict Confidence"

Each depositor insured to $40,000

Branch Offices

Canton East Branch
Bank Of Madison
Bank Of Ridgeland

FDIC

Federal Deposit Insurance Corporation

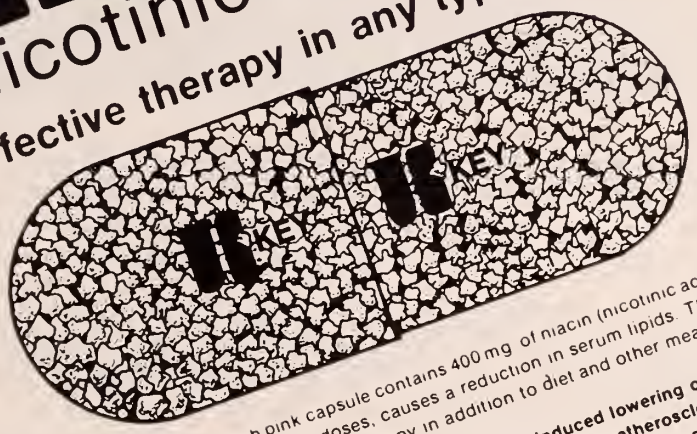
"Our 95th Year Of Continuous Service"

The Original
Slow Release
Form of Nicotinic Acid

nico-Span®

(nicotinic acid) 400 mg. capsules

Effective therapy in any type of drug responsive hyperlipidemia.



DESCRIPTION: Each pink capsule contains 400 mg. of niacin (nicotinic acid) in a special pelletized formulation for prolonged release

ACTIONS: Niacin, in large doses, causes a reduction in serum lipids. The exact mechanism of action is unknown

INDICATIONS: As adjunctive therapy in addition to diet and other measures in the treatment of hypercholesterolemia and hyperbetalipoproteinemia.

Notice: It has not been established whether drug-induced lowering of serum cholesterol or other lipid levels has a detrimental, a beneficial or no effect on the morbidity due to atherosclerosis or coronary heart disease. Several years will be required before current investigations can yield an answer to this question.

CONTRAINDICATIONS: Niacin is contraindicated in patients with hepatic dysfunction or in patients with active acute peptic ulcer.

WARNINGS: The use during pregnancy and lactation or in women of childbearing age requires careful weighing of potential benefits versus possible hazards to the mother and child. There are insufficient studies done for usage in children.

PRECAUTIONS: Patients with diabetes, gall bladder disease, past history of jaundice, liver disease, or peptic ulcer should be observed closely. At initial stage of therapy, liver function and blood glucose should be monitored at frequent intervals. Adjustment of diet and/or hypoglycemic therapy may be necessary. Patients undergoing antihypertensive therapy may experience an added vasodilating effect with resulting postural hypotension. Use with caution in patients predisposed to gout.

ADVERSE REACTIONS: Severe flushing, decreased glucose tolerance, activation of peptic ulcer, abnormal liver function tests, jaundice, gastrointestinal disorders, dry skin, pruritus, hyperuricemia, toxic amblyopia, hypotension, transient headache.

DOSAGE AND ADMINISTRATION: The dose and frequency for the administration of NICO-SPAN should be adjusted to the response of the patient. Slow build-up of dosage in gradual increments is recommended to observe efficacy and/or adverse effects. One or two capsules three times a day is the usual dosage. The maximum daily dosage is 6 grams.

Please arrange to provide starter samples and/or complimentary "Starter" prescription booklets for: **nico-Span®** (nicotinic acid, 400 mg.)

Samples ☐ "Starter" Rx's ☐

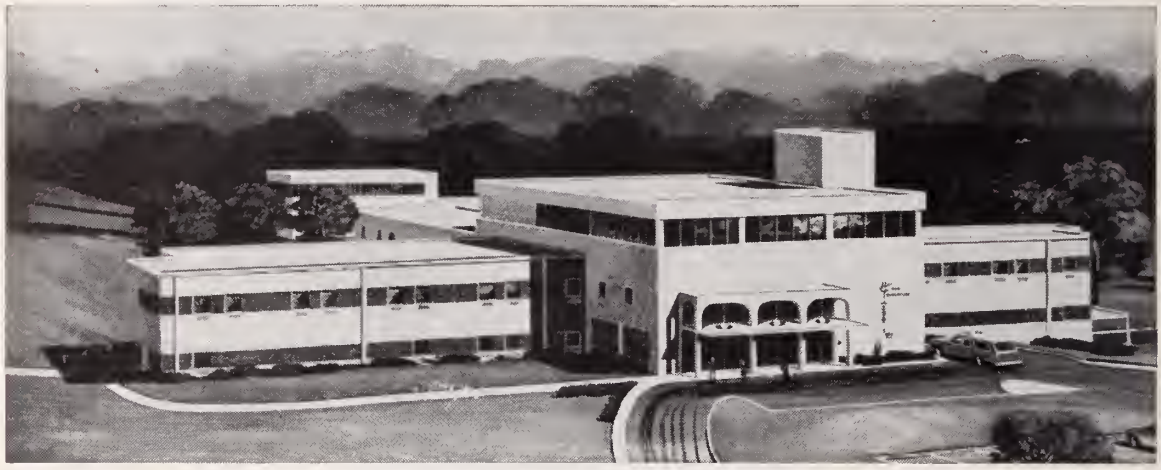
Dr. _____ Specialty _____

Street _____

City _____ State _____ Zip _____

Mail to: Key Pharmaceuticals, Inc. 50 N.W. 176th Street, Miami, Florida 33169

KEY PHARMACEUTICALS, INC.
Miami, Florida 33169 (U.S.A.)



HILL CREST HOSPITAL

For Intensive Treatment of Psychiatric Disorders

This 101-bed non-governmental psychiatric hospital provides modern facilities for diagnosis and treatment of patients with all degrees of illness, including those who show severely disturbed behavior. Alcoholic and drug abuse patients are also accepted.

In addition to care by psychiatrists and by consultants in all medical specialties, the treatment program includes occupational, recreational, and physical therapy, social services, and tutoring. Emphasis is on short-term, intensive treatment of voluntary patients.

Hill Crest is a member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Alabama Hospital Association, Birmingham Regional Hospital Council.

Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved. Blue Cross Participating Hospital.

ADMINISTRATOR: Robert V. Sanders

HILL CREST HOSPITAL

HILL CREST FOUNDATION, INC.

6869 Fifth Avenue South **Birmingham, Alabama 35212**

PHONE: 205-836-7201

NEWSLETTER

September 1976

Dear Doctor:

AMA told the federal Privacy Protection Study Commission that legislation to safeguard confidential health information is needed, but should be at the state rather than federal level. AMA said federal legislation extending Privacy Act of 1974 to the private health care sector would expand the potential for unjustified intrusion by government upon the privacy of patients, would interfere in the patient-physician relationship, and would not be in the interests of the patient.

> AMA presented its model bill which would place reasonable restrictions on access to, use of and further distribution of confidential information by third parties, require written authorization for release; and require third parties to establish minimal security procedures for safeguarding information.

Democratic presidential contender Jimmy Carter of Georgia is preparing a "major speech on health care financing," according to his campaign director, Peter Bourne, M.D. When speaking before the National Press Club, Bourne indicated that Carter will endorse rate setting by Professional Standards Review Organizations (PSROs) or the federal government.

Sales of cigarets have been banned at Johns Hopkins Hospital, Baltimore. The hospital governing board acted in response to a request from Robert Mason, M.D., associate professor of cardiovascular medicine, who recommended that "in its official position as a healing institution, the hospital should refuse to endorse the sale of cigarets."

AMACO -- the American Medical Assurance Company -- was granted a certificate of authority last month by the Illinois Department of Insurance. The AMA's reinsurance company is expected to begin negotiations with physician-owned medical liability companies this month. For more information, contact the Office of Executive Vice President, AMA headquarters, Chicago.

The Mississippi State Medical Association Auxiliary has published its fifty year history, "Torchbearers." Author of the undertaking is Mrs. Catherine Thompson of Columbia. The histories are on sale for $5.25 each and may be purchased from local MSMA auxiliary officers or ordered from Mrs. Thompson, P. O. Box 484, Columbia 39429. (Please enclose 40¢ for postage.)

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

Medicare Has Quiet Anniversary

Medicare and Medicaid recently celebrated their 10th anniversary. Harry Schwartz, a member of the editorial board of the *New York Times*, noted the event and commented that "the politicians are strangely bashful about pointing with pride or otherwise claiming credit." Writing in the June 29 *Times*, Schwartz said: "In retrospect, one of the most important consequences of Medicare and Medicaid has been to delay for many years adoption of comprehensive national health insurance in this country. By aiding the aged and the poor, the programs reduced the political pressure for an all-inclusive system. Simultaneously the huge problems Medicare and Medicaid created—especially in the area of costs—helped cool the ardor of many who might otherwise have been demanding a first priority for national health insurance."

Mr. Schwartz points out that health expenditures in fiscal 1965 were under $40 billion ($5 billion of it federal) but are expected to be $130 billion ($42.5 billion of it federal) in fiscal 1976. "The enormous price inflation for all types of medical services—more than 80 per cent this decade—is properly credited in large part to the explosion of effective demand which Medicare and Medicaid made possible," he writes. "Perhaps the great costs of this learning process are compensated for by the greater sophistication and skepticism with which all interests concerned approach today's proposals for more intimate relations between government and medicine."

RVS Are Recalled

The FTC has announced a negotiated settlement of its charge that the relative value scales of the American Academy of Orthopaedic Surgeons and the American College of Obstetricians and Gynecologists have the effect of "influencing fees charged by their members." The consent agreement includes an order under which the two medical organizations will stop publishing the scales and will recall those already published. The Justice Department has a separate suit against the American Society of Anesthesiologists charging that its relative value scales restrict price competition.

Is there a tablet containing *only* an expectorant and *only* Glyceryl Guaiacolate? YES!



1. Patient acceptable tablet dose.
2. Single entity expectorant.
3. Measured tablet dose.
4. Sugar-free tablet.

An identifiable white, scored tablet which significantly stimulates the secretion of respiratory tract fluid.

HYTUSS TABS

(GLYCERYL GUAIACOLATE 100mg.)



Composition: Each sugar-free compressed tablet contains glyceryl guaiacolate 100mg. **Action and Use:** This preparation utilizes the effective expectorant action of glyceryl guaiacolate which significantly stimulates the secretion of respiratory tract fluid. The increased flow of less viscid fluid favors expectoration and has a demulcent effect on the tracheobronchial mucosa. The primary usefulness of Hytuss Tabs is to promote the change from a dry, unproductive cough to a productive cough. Hytuss is therefore useful in treating coughs due to the common cold, bronchitis, laryngitis, tracheitis, pharyngitis, influenza and the measles. The expectorant action of Hytuss may also provide symptomatic relief in some chronic respiratory disorders when the patient experiences spasms of dry nonproductive coughing. **Precautions:** Extremely large amounts may cause nausea and vomiting. **Administration and Dosage:** *Adults*—1 tablet four times daily. *Children*—6 to 12 years of age; ½ tablet 3 or 4 times daily. HOW SUPPLIED: White, scored, sugar-free, tablet in bottles of 100 - 1,000 - 5,000. **Product Identification Mark:** Hy. **Literature Available:** On request.

Available through all drug wholesalers.

Hyrex

HYREX COMPANY

832 South Cooper
Memphis, Tenn. 38104

Counsel to Authors

THE JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, Miss. 39216, in original and at least one duplicate copy. They must be typewritten double spaced on 8½ by 11-inch white bond paper with a standard typewriter.

The author is responsible for all statements made in his work, including changes made by the manuscript editor. Manuscripts are received with the understanding that they are not under simultaneous consideration by any other publication and have not been previously published. All manuscripts will be acknowledged, and while those rejected are generally returned to the author, the JOURNAL is not responsible in event of loss. Manuscripts accepted for publication become the property of the JOURNAL and are copyrighted by the association when published. They may not be published elsewhere without written release and permission from both the JOURNAL and the author.

All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus,* volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made after proof sheets are received by the JOURNAL.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for illustration engravings not exceeding four column inches per printed page.

Illustrations must be numbered and cited in the text. Legends, not exceeding 40 words and preferably shorter, must accompany each illustration, typed double spaced on separate sheets. The following information should appear on a gummed label affixed to the back of each illustration: Figure number, manuscript title, author's name, and arrow indicating top of the illustration.

In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

A thesis summary of 75 to 100 words must accompany each manuscript separately from the text.

Reprints may be obtained at cost plus shipping charges from the association and should be ordered prior to publication. The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. —*The Editors.*



LUFYLLIN® (dyphylline)

Before prescribing, please review complete product information, a summary of which follows:

Indications: For relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

Precautions: Exercise caution with use in the presence of severe cardiac disease, renal or hepatic malfunction, glaucoma, hyperthyroidism, peptic ulcer, and concomitant use of other xanthine-containing formulations or other CNS stimulating drugs.

Adverse Reactions: May cause nausea, headache, cardiac palpitation and CNS stimulation. Postprandial administration may help to avoid gastric discomfort.

How Supplied:

LUFYLLIN, 200 mg., Tablets: NDC 19-R521-92 bottle of 100, NDC 19-R521-97, bottle of 1000.

LUFYLLIN Elixir: NDC 19-R515-68, pint bottle, NDC 19-R515-69, gallon bottle.

LUFYLLIN Injection: NDC 19-R537-T2, box of 25 x 2 ml ampuls.

For relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

LUFYLLIN®
(dyphylline)

...a basic need for the bronchospastic patient.

Tablets: 200 mg dyphylline
Elixir: per 15 ml: dyphylline 100 mg, alcohol 20% v/v

the bronchodilator with a difference...dyphylline.

A NEED FOR YOUR PATIENT BECAUSE . . . . .

1. Therapeutically effective
2. Little to no CNS stimulation
3. Little to no gastric upset
4. Effective during long-term therapy
5. Only 1/5 the toxicity of theophylline or aminophylline[1,2,3] (based on animal studies)

REFERENCES

1. McColl, J. D., et al.: **J. Pharm. & Exp. Therap.** 116:343, 1956
2. Quevauviller, Par Andre, et al.: **Presse Med.** 61:1480-1482, 1953
3. Maney, P. V., et al.: **J. Am. Pharm. Assoc.** 35:266-272, 1946

Mallinckrodt® Pharmaceuticals *Linking Chemistry to Medicine*®

Mallinckrodt, Inc.
Mallinckrodt Pharmaceutical Division
St. Louis, Missouri 63147

Flu Bill Is Enacted

Congress shortened its scheduled work week and recessed earlier than expected for the Republican Convention, acting before its departure to enact a national swine influenza program which provides liability protection for participants (including physicians) in the forthcoming swine flu immunization effort. The President signed the bill (PL94-380).

In a dramatic "last-day" session, the Senate passed the bill, S. 3735, by a voice vote and promptly adjourned for the recess. The House of Representatives was left with no opportunity to amend the Senate-passed measure and still have the bill available for Presidential approval prior to the Congressional recess. The House acquiesced, approving the bill by a vote of 250-83.

As enacted, the law amends the Public Health Service Act to authorize the Secretary to establish, conduct, and support needed activities to carry out a national influenza immunization program until Aug. 1, 1977. The Secretary is required to make quarterly reports to the Congress on: The current supply of the vaccine; the number of persons inoculated with such vaccine; the amount of funds expended for the program; and the epidemiology of influenza in the U.S. Any contract for U.S. procurement of swine flu vaccine from a manufacturer would be subject to renegotiation to eliminate any profit.

In order to (A) assure an orderly procedure for the prompt and equitable handling of any claim for personal injury or death which results from the administration of the vaccine; and (B) *to achieve participation in the swine flu vaccine program* by manufacturers and distributors of the vaccine, by public and *private entities that provide inoculations without charge for such vaccine or its administration and in compliance with a federal informed consent form,* and by medical and other health personnel who provide or assist in inoculations without charge and in compliance with the informed consent form, the *law would provide that any claim arising under the inoculation program would be asserted directly against the United States.*

POSTGRADUATE CALENDAR

Sept. 13-14, 1976

NEWBORN RESUSCITATION

University Medical Center, Jackson

Sponsired by the University of Mississippi School of Medicine Department of Pediatrics, Division of Newborn Medicine, University of Mississippi School of Nursing, and University Medical Center Division of Continuing Health Professional Education

Coordinator:

Gwendolyn Bussa, M.N., assistant professor of nursing, the University of Mississippi School of Nursing

Physicians, registered nurses, and respiratory therapists will focus on understanding the anatomy and physiology of newborn intubation and identifying the infant who needs resuscitation. Participants will also learn management of the mechanical and pharmacologic needs and manual skills essential to newborn resuscitation. Credit: 12 contact hours, 1.2 CEU.

GENETICS COURSE FOR PHYSICIANS

University Medical Center
September 16, 17, 1976

Sponsored by the University of Mississippi School of Medicine Department of Preventive Medicine, University Medical Center Division of Continuing Health Professional Education, and the National Foundation—March of Dimes

Coordinator:

John F. Jackson, M.D., professor of preventive medicine, the University of Mississippi School of Medicine

During this day-and-a-half course, primary care physicians will study genetic diagnosis and counseling. Fee is $50.00 (tentative). Credit: 12 contact hours, 1.2 CEU, Category I, AMA, AAPF.

PEDIATRICS INTENSIVE COURSE

University Medical Center, Jackson
September 27, 28, 29, 30, October 1, 1976

Sponsored by the University of Mississippi School of Medicine Department of Family Medicine and University Medical Center Division of Continuing Health Professional Education

Coordinator:

J. M. Montalvo, M.D., professor of pediatrics, the University of Mississippi School of Medicine

Physicians will cover such topics as special problems in newborn care; neurology, with emphasis on convulsive seizures; meningitis and head trauma; care and problems of the adolescent; and orthopedic problems in children. Credit: 40 contact hours, 4.0 CEU, Category I, AMA, AAFP.

Lung Association Advises on Flu Vaccination

Concern that chronic lung disease patients may not seek influenza vaccination next fall—or may not receive full protection—was expressed recently by James Kieran, M.D., president of the American Lung Association.

Controversy surrounding the government's mass flu immunization program, and the recommendation that persons at high risk receive two separate vaccines may be confusing to those with lung diseases, Dr. Kieran said.

"So far as risk is concerned, 1976-77 is no different for these 14 million Americans than any other flu season," the California chest specialist said. "Each year, the American Lung Association and its medical section, the American Thoracic Society, recommend that adults with chronic lung diseases be protected against the flu viruses expected to circulate. This year, we advise immunization with both the bivalent vaccine against A/New Jersey/76—the so-called swine virus—and A/Victoria/75, and with monovalent B virus vaccine."

Any lung infection can interfere with the lung's cleansing mechanisms and the supply of oxygen to the body, Dr. Kieran said. For those with diseases such as emphysema, the result may be fatal. Flu can mean serious illnesses for chronic bronchitis victims and those with cystic fibrosis who have reached adulthood.

Flu can exacerbate asthma, and sometimes precipitate attacks, Dr. Kieran said. Even in young adults the results may be serious.

TB patients are at extra risk, because so many are elderly or suffering from other chronic ailments. such as heart disease or diabetes. Any one of these conditions places an individual at high risk when flu strikes.

"Germs find the lungs a hospitable harbor, and many of the 20 million deaths which followed the 1918 flu epidemic are attributed to bacterial pneumonias which followed the influenza illness," Dr. Kieran explained. "Although modern antibiotics can cure these complications, lung disease patients have less chance of surviving than healthy persons."

Dr. Kieran urged physicians and families to make special efforts to be certain adults with chronic lung diseases receive protection against all viruses expected during the 1976-77 flu season. He said recommendations for children with lung diseases would be issued at a later date, based on results of federal clinical trials now underway.

For patients and their families who have questions about flu, the nationwide Christmas Seal association has published a special pamphlet, "Flu—1976-77. The Facts About Your Lungs."

Copies are available from the Mississippi Lung Association, P.O. Box 9865, Jackson, MS 39206 or from the American Lung Association, P.O. Box 596, New York, NY 10001.

Tennessee Internists Meet Oct. 1-2

Specialists in internal medicine and related medical fields from Tennessee will take part in a two-day scientific meeting Oct. 1-2, 1976, in Gatlinburg, TN. Sessions will be at the Glenstone Lodge.

Physicians who attend the regional meeting are eligible for credit toward the American Medical Association's Recognition Award in Category 1.

In charge of planning for the ACP's Tennessee Regional Meeting is Gerald I. Plitman, M.D., Memphis.

it's the real thing

Enjoy Coca-Cola Trade-mark®

70-37

Mississippi Council of Coca-Cola Bottlers

consider the effect on coexisting diabetes when you prescribe a vasodilator*



(POSTERIOR VIEW OF PANCREAS)

no interference in the management of the diabetic patient has been reported with

VASODILAN®
(ISOXSUPRINE HCl)

TABLETS, 20 mg.

the compatible vasodilator

Mead Johnson LABORATORIES

© 1976 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL-54117

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

DATELINE

Taxi Drivers Get OB Training

Chicago, IL - If delivering a pregnant woman to the hospital in a cab turns into delivering a baby in the backseat, a group of cab drivers in Chicago will know what to do, according to the June 1976 American College of Ob-Gyn Newsletter. More than 100 taxi drivers recently attended training sessions in emergency childbirth held at Michael Reese Hospital. The special one-day program for cabbies was conducted by ACOG Fellow Jorge Valle, M.D. and an ob-gyn staff nurse.

Length of Stay Data Published

Ann Arbor, MI - The Commission on Professional and Hospital Activities (CPHA) announces publication this month of the new edition of Length of Stay in PAS Hospitals. The data in these books have been compiled from over 14 million individual patient discharge abstracts submitted by more than 2,000 of the U.S. and Canadian hospitals participating in PAS during 1975. The data have been organized by classifying all patients into 349 diagnosis groups.

Military Med School Admits Initial Class

Washington, D.C. - The Uniformed Services University of the Health Sciences enrolls its charter class of medical students this fall, according to Dr. Anthony R. Curreri, university president. The university has been officially notified by the Liaison Committee on Medical Education that provisional academic accreditation has been granted. Thirty-two students have been informed of their conditional acceptance and are undergoing physical examinations prior to commissioning.

Honor Court is Jail Alternative

Richmond, VA - Individuals charged with crimes related to alcohol misuse have the opportunity to learn new job skills in addition to receiving treatment for alcoholism as an alternative to jail or a fine under a cooperative Virginia project, Pittsylvania County Honor Court. Individuals joining the program are sent to Danville Alcoholism Treatment Center for medical and group therapy and to the Department of Vocational Rehabilitation for job counseling and job training.

Leadership Training Offered Physicians

Alexandria, VA - The American Academy of Medical Directors in cooperation with the American Group Practice Foundation has been awarded a three year grant by the Robert Wood Johnson Foundation to train physicians for positions of organizational leadership. The training program consists of two five-day courses to be conducted in eleven locations throughout the country. For further information, contact Roger S. Schenke, project director, 20 S. Quaker Lane, Alexandria VA 22314.

Five-State Pediatric Pulmonary Conference Set

The second LAMOT Pediatric Pulmonary Case Conference, sponsored by Lung and Thoracic Societies of five states, will be held Sept. 17-18, 1976, in Shreveport at the Chateau Motor Hotel.

The LAMOT Conference, acceptable for 9 prescribed hours by the American Academy of Family Physicians, will be of interest and benefit to specialists in internal medicine, family practice, radiology, in addition to general pediatrics and pulmonary pediatric practice. Endorsed by the American Thoracic Society, LAMOT Conference takes its name from the five sponsoring states of Louisiana, Arkansas, Mississippi, Oklahoma, and Texas.

Dr. Suzanne Miller, assistant professor of pediatrics, University of Mississippi Medical Center, is conference chairman. She will also present a series of cases on pleural fluid. Other representatives of MLA and the Mississippi Thoracic Society presenting cases will be Dr. Wilfred Cole, associate clinical professor of pediatrics, and Dr. Linda Walters, assistant professor of pediatrics, both of University of Mississippi Medical Center.

Other topics for case presentation include bronchitis and sinusitis, bronchiectasis, epiglottitis and laryngotracheobronchitis, foreign bodies in the respiratory tract, and special presentations on bronchoscopy.

Other participants will be Dr. Gunyon M. Harrison, Baylor University of Medicine; Dr. John C. Kramer, University of Oklahoma College of Medicine; Dr. Rosalind Abernathy, University of Arkansas Medical Center; Dr. Bettina C. Hillman, LSU Medical School; Dr. Charles Ewing, Baylor College of Medicine; Dr. William W. Waring, Tulane University Medical School; and Dr. Howard Eigen, University of Indiana School of Medicine.

Visiting guest consultants include Dr. Virgil Condon, associate professor of radiology, associate professor of pediatrics, University of Utah, Salt Lake City; Dr. Paul Holinger, professor of bronchoesophagoscopy, department of otolaryngology, Abraham Lincoln School of Medicine, University of Illinois, Chicago; and Dr. Henry Levison, associate professor of pediatrics, University of Toronto; director of respiratory physiology, The Hospital for Sick Children, Toronto, Ontario, Canada.

The LAMOT Conference, providing postgraduate opportunities, is part of the medical and professional education program of workshops and seminars made possible by Christmas Seal contributions and Memorial Gift donations. For further information, contact the Mississippi Lung Association, P.O. Box 9865, Jackson, MS 39206.

FAMILY PRACTICE PHYSICIANS

Openings for Family Practice Physicians in group practice. Excellent starting salary. If performance and qualifications are fulfilled, a sharing partnership is possible. Physician owned hospital adjoining. This is an opportunity to practice family medicine as training in this specialty is intended. Only U. S. medical school graduates need apply. Third year resident applications are encouraged.

Contact

John M. Canakaris, M.D.,
Bunnell General Hospital
Bunnell, Florida 32010
Telephone (904) 437-3354

Arkansas Internists Meet in October

Specialists in internal medicine and related medical fields from Arkansas will take part in a two-day scientific meeting at the University of Arkansas Medical Center, Little Rock, on Oct. 22-23.

The Arkansas Regional Meeting of the American College of Physicians (ACP) is designed to bring physicians up-to-date on late developments in the field of internal medicine. It is one of 39 such sessions held each year throughout the United States and Canada by the 34,000-member medical specialty society.

Physicians who attend the regional meeting are eligible for credit toward the American Medical Association's Recognition Award in Category 1.

In charge of planning for the ACP's Arkansas Regional Meeting is Joseph H. Bates, M.D., Little Rock, who serves as the medical specialty society's representative in Arkansas.

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*



Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Warning**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F CO., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE



When Big Ben looks "a little off"...

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

▪ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

▪ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*

▪ **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

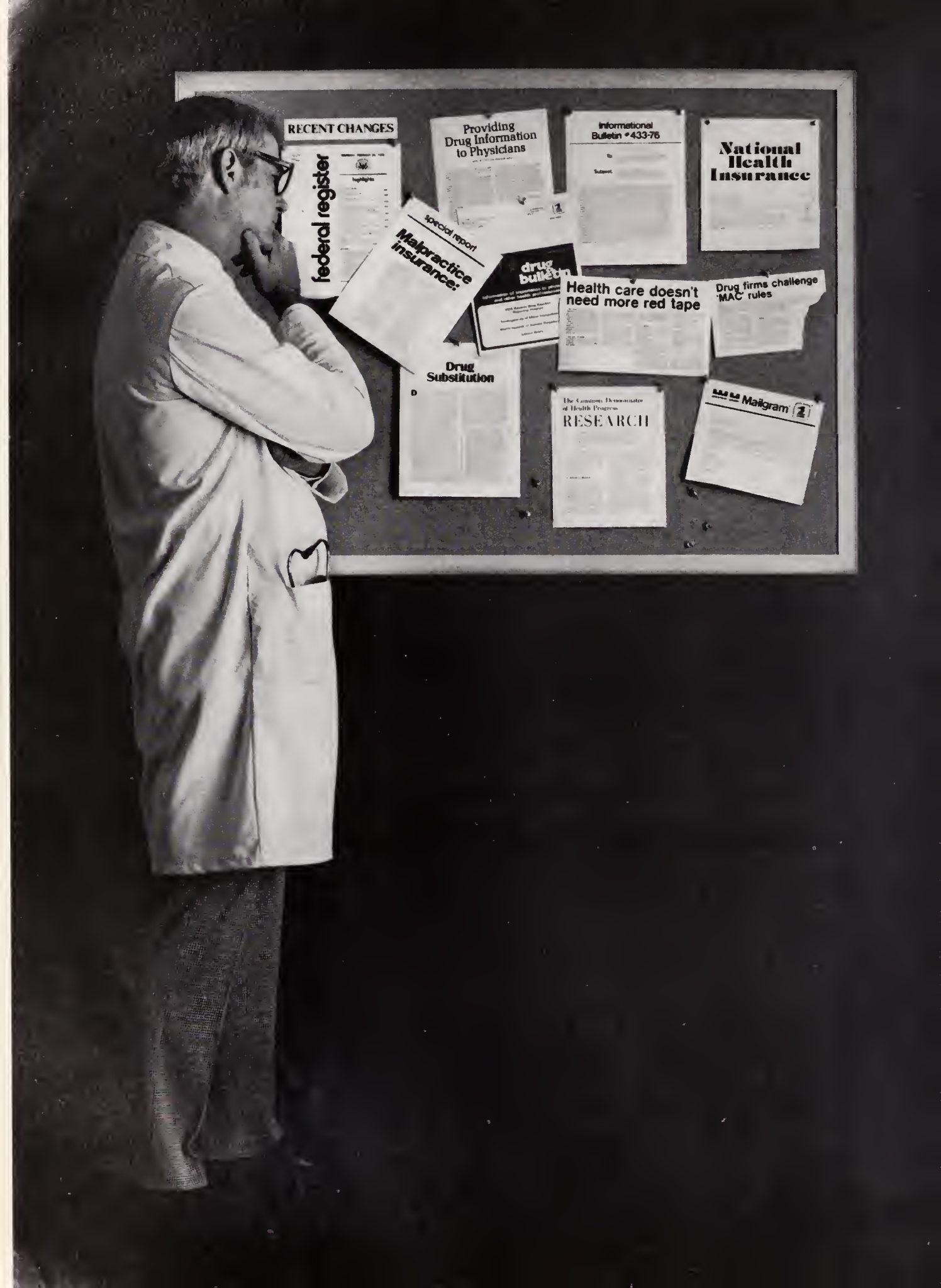
Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017


RECENT CHANGES
federal register
Providing Drug Information to Physicians
Informational Bulletin #433-76
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Management of Emotional Problems Studied

Mini-residencies for medical and surgical practitioners in "Office Management of Emotional Problems" (one, two and three week courses) are offered by the University of Kentucky Medical Center for a minimum of 40 hours per week.

Tuition fee is $350.00 per week for the first and second week of training; $500.00 for third week of supervised practice with patients in the Intensive RBT Treatment Program.

The objective of this course is to give physicians an ideal emotional counseling technique that fits busy office practices. The technique uses a concept of emotions consistent with human anatomy and psycho-physiology. Yet, the technique requires no more physician time or patient cost than routine evaluations of new patients. Finally, the technique is readily understandable and easy for practitioners to apply.

For further information, write to: Maxie C. Maultsby, Jr., M.D., Office of Continuing Education, Department of RBT, University of Kentucky, Lexington, KY 40506.



COMPASS MARK I VAN LIFT

☐ *750 lb. capacity — safer*
☐ *4000 lb. test side safety strap*
☐ *advanced electronic motor control*

The COMPASS COMMUTER:

☐ *40% grade ability*
☐ *4 speeds — 25 mile range*
☐ *indoor/outdoor go-ability*

For More Information Contact
Compass Industries, Inc.
715 - 15th St., Hermosa Beach
CA 90254 213-379-7080

Businesses Turn to Self-Insurance

The May 17 issue of "Business Week" reports that more and more companies are switching to self-insurance of employees for health coverage as a means of avoiding inflationary health care costs. For every company that has switched, another five are studying the possibility of going the self-insurance route.

The report also states that some companies are developing claims-monitoring systems as another attempt to control their health care costs, while others are making efforts to get more involved in local health care planning.

The Upjohn Company has provided home health care coverage for its employees since March 1971. When used, this coverage has resulted in a savings of approximately $270 per case. According to Paul M. Millholland, manager, benefits administration, the basic reason for adding home care coverage to the Upjohn medical insurance plan was to reduce hospital expense paid by the plan. It also gives the employees or members of his family the opportunity to recuperate in the more relaxed home atmosphere, while at the same time relieving the space problem plaguing most large hospitals.

The home care coverage has added no additional administrative burden to either the Upjohn benefit staff or the doctor. While the doctor must certify in writing that the home health care is in lieu of additional hospital confinement, and indicate the number of days and type of care necessary, he may do this by making an additional statement on the claim form or by merely writing it on a prescription pad.

Americans Seek Unneeded Treatment

Health care costs are rising. Last year $1 of every 10 earned by Americans went to pay medical bills, a 10 per cent increase over the year before.

If a recently published book is correct, health care costs are spiraling because Americans are seeking treatment they do not need. *Take Care of Yourself,* written by Donald M. Vickey, M.D., Georgetown Medical School, and James Fries, M.D., Stanford Medical School, questions the need for extensive medical services.

The authors call the idea of routine checkups as a means of preventing sickness largely a myth.

"Even those elaborate checkups which take several days do not detect early and treatable diseases with any regularity," they say.

Even multiphasic screening is looked upon by the authors with disfavor. "Experience with these screening systems over several years has shown that many laboratory abnormalities can be detected but that hardly any problems which need immediate treatment are found. Doctors are required to follow up on the minor laboratory abnormalities, increasing cost and worry to the patient," they state.

The elimination of smoking, two-martini lunches, overeating, and abusing tranquilizers and other drugs—plus the maintenance of physical fitness—far outweigh the advantages to be gained from routine checkups. There are exceptions: skin tests for TB, Pap smears for women over 25, breast examinations, a glaucoma test, urinalysis, and blood pressure checks are necessary, the authors contend.

Course Planned on Tumor Localization

A course in "New Methods in Tumor Localization" will be held Oct. 7-9, 1976, at the University of Kentucky Medical Center, Lexington. Registration fee is $150.00.

For further information, contact: Frank R. Lemon, M.D., Continuing Education, College of Medicine, University of Kentucky, Lexington, KY 40506.

Insect Allergy Symposium Set

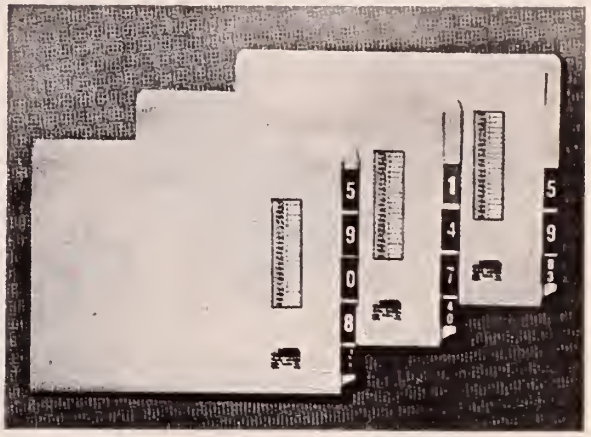
Dr. Claude A. Frazier, an allergist from Asheville, NC, will be conducting a one-day symposium on the subject of insect allergy at the combined meeting of the Pan American Medical Association and the Florida Allergy Association. This symposium is scheduled for Oct. 26, 1976, from 11:00 a.m. to 12:30 p.m. and from 2:00 p.m. until 5:30 p.m., at the Diplomat Hotel in Hollywood, FL. This meeting takes place the week of Oct. 24-29.

Among the eight speakers who will be participants are Donald R. Hoffman, Ph.D., associate professor of pathology, Creighton University, Omaha, NE; Dr. Osmond P. Breland, professor of zoology, University of Texas at Austin; John J. Pisano, Ph.D., head, physiological chemistry, NIH; Dr. Elisabeth C. Beck, entomologist, Florida Health & Rehabilitative Services; Lt. Col. James A. Vick, M.C., Office of the Surgeon General, The Pentagon; Dr. Donald Wiedhaas, laboratory director, U. S. Department of Agriculture, Gainesville, FL; Edward Press, M.D., Oregon State Public Health Officer; and Dr. Frazier, author of *Insect Allergy: Allergic and Toxic Reactions to Insects and Other Arthropods* (Warren H. Green).

Various aspects of insect allergy will be covered in this symposium, including: "stinging insect allergy: *in vitro* diagnosis and identification of allergens," "biology, habits and appearance of insects with illustrations," "pharmologically active substances in hymenoptera venoms," "methods of prevention—repellents and pesticides," "the identification of insects which affect human health," "reactions to Douglas fir tussock moth," "treatment of insect sting reactions," and "medical studies of insect venoms."

WHY OUR COLOR CODED FILING SYSTEM?

REDUCES FILING TIME
ELIMINATES MIS-FILES
NO NEED TO REPLACE YOUR PRESENT FOLDERS



PRINTING — OFFICE DESIGN, FURNITURE & SUPPLIES

Mississippi Stationery Company
277 East Pearl Street — Jackson, Mississippi 39201

FOR MORE INFORMATION
CALL COLLECT (601) 354-3436

Utilization Review:
A Shared Responsibility



As public and governmental pressures grow to provide adequate health insurance coverage as well as accessible medical care, the relationships of the Blue Cross and Blue Shield Plan with the public, providers, and physicians become more complex. Simultaneously, the Plan's responsibility for proper utilization of health care coverage and medical services also increases.

Too often, subscribers do not realize that there are necessary limits on their health care coverage. Physicians are concerned with patient care and are not expected to be, nor should they have to be, experts in health care insurance. Since the limitations of health care coverage are sometimes not clearly understood by subscribers, physicians, and providers alike, a utilization review program is essential.

Utilization Review is part of the Plan's continuing effort to assure proper use of health insurance benefits and medical services. Through Utilization Review, the Plan is able to monitor and identify patterns of utilization. Its purpose is to help control health care funds in such a way that subscribers, providers, and physicians assume a share in responsible and proper utilization of health care benefits and services. Control mechanisms such as Utilization Review, local peer review, and PSRO help assure that we will all be able to obtain quality medical care as well as adequate health insurance coverage at reasonable costs.

Blue Cross®
Blue Shield®
of Mississippi

P. O. Box 1043 / 530 E. Woodrow Wilson Ave.
Jackson, Mississippi 39205 / Tel. 982-0010

* Registered Marks Blue Cross Association
* Registered Service Marks of the National Association of Blue Shield Plans

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
September 1976, Vol. XVII, No. 9

ORIGINAL PAPERS

Maternal and Neonatal Herpes Infection

ROBERT A. DALE, JR., M.D.
Jackson, Mississippi

This paper is developed from a presentation made at University of Mississippi Medical Center Department of Obstetrics and Gynecology Grand Rounds in 1975. An illustrative case report is given and is followed by a review of maternal and neonatal herpes infections. The author discusses general concepts of herpetic discusses general concepts of herpetic disease, ease, transmission and management.

CASE REPORT

THE PATIENT was a 16-year-old black G_2 P_{1001} admitted to the Obstetrical Service of the University of Mississippi Medical Center Hospital at 32 weeks gestation with a chief complaint of ruptured membranes for approximately 7 hours and not in labor.

General physical examination was normal; the cervix was 1 cm dilated, 60 per cent effaced and the vertex was at a minus 1 station. Membranes were not palpable and the nitrazine test was positive for amniotic fluid.

The vulva displayed several lesions characteristic of herpesvirus vulvitis.

The prenatal course had been normal and the patient had been followed by the Nurse Midwifery Service for an uncomplicated pregnancy except for vaginitis. The patient's prenatal laboratory work was normal, and a Pap smear done three months prior to admission was negative. Past pregnancy history and past medical history were normal.

During the hospital course, a Pap smear was taken of the vulvar lesion and the report confirmed the diagnosis of herpes simplex. Approximately 9 hours after ruptured membranes, staff consultation was obtained and it was felt that a cesarean section should be done even though the membranes had been ruptured over 4 hours. A low cervical transverse cesarean section was done without complication and a 2600 gm male infant, Apgars of 8/9 was born.

Pediatric examination of the newborn revealed it to be a premature infant appropriate for gestational age at approximately 37 weeks. Head circumference and length were normal; but he had bilateral conjunctivitis. The remainder of the physical examination was normal.

The infant fed well initially and throughout its 8 day hospital stay. A lumbar puncture in the hospital was normal and all cultures were negative.

The patient's conjunctivitis cleared by the second day and he was discharged to home with his mother on the eighth day of life feeding well and without obvious lesions.

The mother's postpartum course was complicated by a temperature of 102° postoperatively for 6 days which responded slowly to the appropriate antibiotics. All cultures were negative and what was felt to be a bladder flap hematoma was noted on pelvic examination.

On the third postoperative day the vulvar lesions were treated with neutral red and fluorescent light and these were noted to be responding to treatment during the remainder of her stay.

She was discharged on the eighth postoperative day afebrile and on antibiotics to be followed at the Family Planning Clinic.

From the Department of Obstetrics-Gynecology, University of Mississippi Medical Center, Jackson, MS.

The infant was followed at home by a family nurse practitioner. At 2 weeks of age it was felt that the baby was not gaining weight satisfactorily. At 3 weeks he had lost ½ pound from the previous week; however, he had been having episodes of diarrhea at that time. More recently the infant has been reported as feeding well, gaining weight and without obvious neurological disease.

INTRODUCTION

It is indeed fortunate that maternal and neonatal herpes infections occur infrequently because this is often a devastating disease in newborns and can be debilitating and painful in adults.

Historically the spectrum of herpetic infections and their significance have been recognized only in more recent years. One of the earliest diseases associated with herpes was carcinoma of the cervix; however, the importance of maternal and neonatal herpes is more apparent and is a subject which all practicing physicians and paramedical personnel dealing in the field of obstetrics and gynecology should be aware.

GENERAL CONCEPTS OF HERPETIC DISEASE

We should be aware of some basic facts essential to the understanding of the disease. First, there are two strains of herpesvirus, type I and II, which are serologically (and usually) clinically distinct.

Herpes type I infections characteristically occur above the waist and commonly manifest themselves as a fever blister or upper respiratory tract infection.

Herpes type II manifests itself as a genital infection with the more frequently involved sites being the labia, cervix, and perineum. For this reason herpes type II is often referred to as "genital herpes." It is this strain of the virus which is *most often* responsible for herpetic infections in the newborn.[1] Over 95 per cent of genital herpevirus isolated from women are type II[8] and it is also this type that is isolated in 90 per cent of the infected neonates. The remainder of the discussion will thus be devoted primarily to type II infections.

Herpes type II infection is also considered a venereal disease. This infection is found four to six times more frequently in prostitutes than in the general female population and rarely in children and celibate women.[2] Upper middle class women have a low incidence of virus recovery from the genitourinary tract.[3] High rates of infection have been found in venereal disease clinic patients,[4] and the infection is frequently associated with other venereal infections such as Hemophilus vaginitis, Trichomoniasis, and Condoloma Accuminata.[5] One investigation indicated that the male genitourinary tract serves as a reservoir for herpes II virus.[6]

Clinically, genital herpes may present as a primary or recurrent infection. Eighty-five per cent of primary herpesvirus type II infections are subclinical, but the clinically apparent infection is usually manifested by severe vulvovaginal discomfort, watery discharge, dysuris,[7] malaise, and pyrexia,[8] and is often associated with enlarged tender inguinal nodes.[9] The incubation period is two to seven days.[8] The disease begins with prodromal itching and pain over the infected area. Vesicles soon develop. These in turn rupture and form shallow exquisitely painful ulcers. The primary infection lasts seven to fourteen days,[9] is more commonly seen on the labia,[8] and at its most painful state may resemble second degree burns.

The differential diagnosis of genital herpes includes trichomoniasis, gonorrhea, primary and secondary syphilitic ulcers, chancroid, lymphopatheum venereum, and scratch lesions of puritus vulvae, abrasions, and leukoplakia.[8]

The recurrent infection is usually less severe and often asymptomatic with no overt lesions. As with fever blisters, these recurrences are frequently precipitated by stress and may be noted following menstrual periods, fever, and during pregnancy.[9]

Diagnosis of this infection may be in one of three areas; virology, immunology, and cytology.

(1) The viral diagnosis depends upon viral growth in certain culture media such as human diploid fibroblasts, chicken embryo, or rabbit kidney.[1]

(2) Immunological diagnosis depends upon the production of host antibodies to the virus. Both herpesvirus I and herpes II are antigenically distinct, thus the host produces a specific antibody to the involved virus.[8] These may be detected by serological tests such as the cross-neutralization or the immunofloresccnce tests.[1] A large portion of the adult population has herpesvirus I antibodies, but only 20 per cent have herpesvirus II antibodies. A primary genital herpetic infection may be diagnosed if initially there is no antibody titer to herpesvirus II and then there is a rise in this titer during the convalescent period. However, once elevated, after a primary infection, the titers remain elevated indefinitely, secondary to persistence of the virus in the tissues.[7] Thus, clinical infections with initially high titers indicate recurrent infections.[5]

(3) Cytology is a rapid, easy way to make a diagnosis of herpesvirus infections[8] and is the only available method at the University of Mississippi Medical

Center. It may be done by Pap smear or on Giesma or Hematoxylin and Eosin stained slides. Herpesvirus produces two characteristic cellular changes: 1) Multinucleated giant cells which differ from foreign body giant cells, 2) eosinophilic intranuclear inclusion bodies.[7]

Treatment for genital herpes infections has been very disappointing until recently with the introduction of photodynamic dye inactivation. The most commonly used dyes are neutral red and proflavin. These dyes, in the presence of florescent light, oxidize viral DNA and prevent replication. They have been observed to produce dramatic symptomatic relief.[10] However a recent *Medical Letter* indicates that these dyes may be potentially carcinogenic because oxidation of the viral DNA causes breaks in the chromosomal structure.[11] Another commonly used drug is iododeoxyuridine, an antiviral agent. This drug has been shown to be less effective in treating herpesvirus II than herpesvirus I infections.[12] Other modes of treatment still in the experimental stages are BCG administration,[9] small pox vaccine, and interferon.[8]

MATERNAL HERPES TYPE II INFECTIONS

The incidence of herpesvirus II infection in pregnancy is between 1/1500 and 1/1000 with an increased incidence in the lower socioeconomic groups.[8] Virological and cytological specimens from the cervix or vagina indicate maternal genital herpes infections are three times more common during pregnancy than in the non-pregnant female, and the incidence increases as pregnancy progresses.[12]

An explanation for the higher incidence in late pregnancy may be that a cell mediated immune response, in addition to the host's production of neutralizing antibodies, is required for full protection against infection. It has been recently shown by Anderson and others that the cellular immune mechanisms are depressed during pregnancy. Several animal studies have shown a decreased macrophage response associated with an increased susceptibility to herpes infections during pregnancy.[9] Nahmias has shown that herpesvirus type II is isolated from the cervix more often in late pregnancy than earlier pregnancy.[13] He estimates that 40 per cent of the women with genital herpes at the time of vaginal delivery will infect their infants.[14]

The risk of maternally spread neonatal herpes infection is highest in infants born to women with primary genital herpes occurring two to four weeks before delivery.[12] Some primary and most recurrent infections are asymptomatic and thus the diagnosis may not be clinically apparent.

TRANSMISSION

Transmission of herpesvirus apparently occurs in several modes.

(1) The most common is acquisition by the fetus, during the second stage of labor when the fetus comes in contact with lesions in the birth canal. The risk of infection by this route seems to be associated with a) a high titer of virus inoculum in the lesions, b) increased vulnerability of exposed surfaces during the first and second stages of labor, and c) with the type and severity of maternal infection. If the infection is recurrent the fetus has IgG antibodies to the virus transmitted transplacentally from the mother and thus is better protected.[12]

In 1965 Yen proposed that fetal mortality was directly related to the infant's antibody titer at the time of exposure.[15] However, this is probably not as satisfactory protection as cell mediated immunity. Thus as stated previously, the greatest hazard to the neonate is with a primary infection two to four weeks prior to delivery,[12] as the virus is usually still present in these cases.

(2) Another means of viral transmission is via an ascending infection from the lower genitalia if the membranes have previously been ruptured.

An infection can become established within six hours after ruptured membranes. It should be noted that an intrauterine herpetic infection may be the cause rather than the consequence of spontaneously ruptured membranes, therefore making a cesarean section of no value since the fetus is already infected at the time the membranes rupture.[16]

(3) Transplacental viral transmission has been documented and is probably the route of infection in early pregnancy.[8] These early infections are often associated with first trimester abortion and congenital malformation,[12] especially in the central nervous system.[17] The incubation period in the neonate is two to twelve days. Thus lesions present at delivery or appearing within the first day of life indicate infection acquired before birth. Witzleberg and Driscoll documented a herpetic infection in a placenta of a newborn which did not develop infection until six days after delivery.[12] The greatest risk of transplacental transmission is in patients with lymphadenopathy and fever as the occurrence of viremia is highest then.

(4) It has been proposed by Gallman that an endometrial infection may be a source leading to fetal involvement. He reported a case of missed abortion in which the D&C revealed a specimen of endometrium with nonsecretory glandular complexes con-

taining characteristic herpetic intranuclear inclusions. However it is not known whether the endometrium is infected hematogenously or via the ascending route.[18]

(5) Postnatally, infants may be infected by contact with other people with hepetic infections,[19] especially nursery personnel and relatives.

MANAGEMENT

If the maternal infection has occurred within two to four weeks prior to delivery and membranes are intact, cesarean section should be done. If membranes are ruptured four hours or less, cesarean section should be done. If membranes have been ruptured for more than 4 hours, it is doubtful if cesarean section will protect the baby and thus the baby should be delivered vaginally.[8]

NEONATAL INFECTIONS

In neonates the incidence of infection is four to five times greater in premature than in term infants. This is probably secondary to the low level of maternal IgG and/or the inability to provide adequate cellular immune response at this early age. On the other hand, patients who have cytological evidence of herpetic infection have an increased rate of prematurity suggesting the infection as the cause. It has been observed that a premature infant with herpes has approximately the same chance of survival as a term infant with herpes. However, the premature infant is at higher risk for developing central nervous system sequelae which may be attributed to either the infection or the prematurity itself.[12]

Infections in early and mid pregnancy may carry the risk of fetal death, malformation,[8] and abortion.[12] The major developmental anomalies acquired during this period are aremicrophthalmia, retinal dysplasia, intracerebral calcification, seizures and mental retardation.[8] Hydrocephalus in not a feature of herpes infections.[20]

Although the greatest risk to the neonate for acquiring herpetic disease is with a primary maternal infection late in pregnancy, it must be noted that even mild or clinically inapparent maternal infections may lead to a wide spectrum of neonatal disease manifestations, from a localized infection at one end of the spectrum to a fatally disseminated one on the other end. Presenting symptoms are variable and may include a papulovesicular rash, respiratory distress, seizures, gastrointestinal bleeding (most likely due to disseminated intravascular coagulation), and hypoglycemia. Nahmias reported in one study that 54 per cent of infected infants had the rash, and thus skin vesicles may be an early clue to the diagnosis. Lesions may appear anywhere on the skin, but most commonly occur over the scalp with vertex presentations and over the perianal area in breech presentations. Conjunctivitis followed by keratitis is often the first abnormality noted. The infection may remain localized or progress to a more widespread form in the first few days. It is often not suspected until the typical skin lesions are noted to be associated with signs of fever, vomiting, failure to feed, irritability, or lethargy.[12]

Herpetic neonatal infections often involve the central nervous system as the dominant clinical feature. The cerebrospinal fluid occasionally contains herpesvirus secondary to increased permeability of the CNS to infectious agents during the neonatal period. The liver and adrenals are very often affected in the disseminated form of the disease with the pathological lesion being focal coagulative necrosis without an inflammatory infiltrate.[12]

The diagnosis of neonatal herpetic infections is usually made clinically. Cytological diagnosis is very satisfactory with Pap smears being taken from a lesion on the newborn and also from the mother's cervix. Serology is not useful for early diagnosis as infant IgM antibody titers do not become elevated before this rapidly progressing disease takes its course. Because the herpesvirus is readily cultured, viral studies may be helpful. Typical cytopathic changes can be noted within 24 to 48 hours after inoculation of the culture.[12] This is not presently available at the University Medical Center.

The differential diagnosis in the neonate includes toxoplasmosis, syphilis, listerosis, varicella, rubella, and cytomegalovirus. These diseases are known collectively as the "TORCH" organisms.[21]

In treating neonatal herpes infections serum immune globulin has been used with poor results. Its early use is still advocated, however, because of the possibility of preventing disseminated disease. It is not useful in disseminated disease.[12]

Iododeoxuridine has been popularly used; however, its effectiveness is uncertain. In one series of 11 cases of disseminated herpes infections treated with this drug, three infants died and six of the eight survivors had neurological sequelae. Side effects of this drug include a decreased platelet count, alopecia, diarrhea, and stomatitis. It is important to note that if an infant does survive, it will most likely have residual neurological damage and will possibly require life long insitutional care.[12] Thus, the use of iododeoxyuridine becomes an ethical dilemma.

Antibiotics are often used to prevent secondary bacterial sepsis associated with disseminated disease.

The more common offenders are gram negative bacteria and hemolytic Staph. aureus. Steroids have not been shown to be effective. Heparinized whole blood transfusions may be used in patients with clotting deficiencies secondary to liver involvement.[12]

Prophylaxis for the newborn consists of abdominal delivery and treatment of maternal infections with topical agents.[21] Amniocentesis for virus isolation has been proposed and tried, but to date no isolation has been accomplished by this method.[12]

Prognosis for the newborn depends largely upon whether or not the disease is disseminated and central nervous system involvement is present. The prognosis for infants with localized disease of the skin, eye, or oral cavity is more favorable.[12] However, a case was recently reported in which a mild episode of neonatal herpes infection led to the development of severe psychomotor retardation 18 months later.[8] In one study all 29 infants with localized disease survived, but 11 had neurological sequelae. Patients having central nervous system disease have a poor long term prognosis. Little is known about the prognosis in clinically asymptomatic newborns, but it may mimic cytomegalovirus and toxoplasmosis infections and become slowly apparent neurologically over a period of several years.[12]

SUMMARY AND CONCLUSIONS

1) Herpesvirus hominis type II is responsible for over 90 per cent of the newborn and 95 per cent of the maternal genital infections.

2) It is transmitted as a venereal disease between adults and from mother to fetus by ascending infection from the labia, vagina, and cervix; transplacentally; or most commonly by direct contact during labor and delivery.

3) Management would appear to be cesarean section in those cases diagnosed within 2-4 weeks of delivery and with membranes either intact or ruptured less than 4 hours. Vaginal delivery may be carried out if membranes have been ruptured more than 4 hours.

4) Maternal treatment is, at the present time, photoactive dye; however, the patient must be informed of the increased risk of genital cancer that may be secondary to this therapy. ★★★

2500 North State Street (39216)

REFERENCES

1. Person, D.: The Laboratory Diagnosis of Virus Infections in Gynecology and Obstetrics. Clin. Obstet. Gynec. 15:877-895, 1972.
2. Editorial: Sexual Activity and Cervical Carcinoma. J. Iowa Med. Soc. 61:559, 1973.
3. Josey, W.: Summary of Informal Discussion of Part 1 of Genital Herpesvirus. Cancer Research 33:1464, 1973.
4. Editorial: Genital Herpes Simplex. Med. J. Aust. 1: 471-472, 1973.
5. Kaufman, R., Gardner, H., Rawls, W., Dixon, R. and Young, R.: Clinical Features of Herpes Genitalis. Cancer Research 33:1446-1451, 1973.
6. Centifanto, Y., Drylie, D., Deardourff, D. and Kaufman, H.: Herpesvirus Type II in Male Genitourinary Tract. Science 178:318-319, 1972.
7. McIndoe, W. and Churchouse, W.: Herpes Simplex of the Lower Genital Tract in the Female. Aust. N. Z. J. Obstet. Gynec. 12:14-23, 1972.
8. Poste, G., Hawkins, D. and Thomlinson, J.: Herpesvirus Hominis Infection of the Female Genital Tract. Obstet. Gynec. 40:871-890, 1972.
9. Anderson, F., Ushijima, R. and Larson, C.: Recurrent Herpes Genitalis. Obstet. Gynec. 43:797-805, 1974.
10. Friedrich, E.: Relief for Herpes Vulvitis. Obstet. Gynec. 41:74-77, 1973.
11. The Medical Letter: Photoactive Dyes for Recurrent Herpes Simplex. 16:111-112, 1974.
12. Hanshaw, J.: Herpesvirus Hominis Infections in the Fetus and the Newborn. Am. J. Dis. Child. 126:546-555, 1973.
13. Leinikki, P., Donner, M. and Lapinleimu, K.: Herpes Simplex Virus Infection in the Newborn. Arch. Dis. Child. 47:97-103, 1972.
14. Amstey, M., Nasello, M. and Hochberg, C.: Multiple Virus Isolations from a Pregnant Patient. Am. J. Obstet. Gynec. 115:897-900, 1973.
15. Kurata, T., Kurata, K., Aoyama, Y., Hondo, R., Yoshino, K. and Kawana, T.: A Fatal Case of Type II Herpes Simplex Virus Infection in a Newborn. Japan J. Exp. Med. 43:475-482, 1973.
16. Altschuler, G.: Pathogenesis of Congenital Herpesvirus Infection. Am. J. Dis. Child. 127: 427-429, 1974.
17. Hare, M.: Neonatal Encephalitis Following Maternal Genital Herpesvirus Infection. Pro. Roy. Soc. Med. 67: 15-16, 1974.
18. Goldman, R.: Herpetic Inclusions in the Endometrium. Obstet. Gynec. 36:603-605, 1970.
19. Flanders, R., Person, D., Orren, J., Adams, J. and Rawls, W.: Is Herpes Simplex Infection of the Newborn Preventable? Clin. Ped. 11:293-294, 1972.
20. Keith, C.: Congenital Choroido-Retinitis and Cerebral Damage from Unidentified Infective Agents. Med. J. Aust. 1:177-181, 1974.
21. Nahmias, A. J., Josey, W. E. and Naib, Z.: Significance of Herpes Simplex Virus Infection During Pregnancy. Clin. Obstet. Gynec. 15:929-938, 1972.

"No physician, insofar as he is a physician, considers his own good in what he prescribes, but the good of his patient; for the true physician is also a ruler having the human body as a subject, and is not a mere moneymaker."

Plato
The Republic

Problems in Abdominal Surgery
V. Incisional Hernia

WILLIAM O. BARNETT, M.D.
Jackson, Mississippi

THE COMMONLY obese patient with a large incisional hernia involving the abdominal wall represents a surgical prospect which is not overly attractive in many instances. Quite often there have been multiple previous attempts at repair with recurrence appearing early during convalescence. The patient is told to lose weight and to return for surgery after this has been accomplished. Actually, the weight reduction never reaches the desired level and they go along for years with the hernia growing larger. Documentation of some helpful principles has merited a reevaluation of the management of those patients.[2]

Prevention. Certain factors are well recognized as predisposing to the development of hernia after abdominal surgery.[1] Obesity certainly plays a role, and preoperative weight reduction is desirable if it can be achieved. Protein deficiency begets poor wound healing. Patients with cancer and diabetes are more likely to evidence a predisposition to impaired healing. Other factors include vitamin deficiency, the type of incision, hematoma, infection, straining during the period of recovery from anesthesia and advanced postoperative abdominal distention.

Reasons for Advising Surgical Correction. Most patients with hernia should be advised to accept repair. The lesion represents a mechanical, as well as a cosmetic inconvenience. Incisional hernias grow progressively as time passes. Without abdominal wall muscle integrity the cough mechanism is materially impaired. An even more serious and life-threatening consideration is the constant possibility of intestinal obstruction and bowel gangrene. Adhesions develop in most instances with resulting incarceration. Over the years, more organs assume residence in the hernia, which promotes shrinkage of the abdominal cavity. This circumstance of "loss of domain" is but an additional challenge along with the many other problems which operate against successful surgical repair.

Basic Principles Relating to a Successful Repair. Most abdominal wall hernias (other than umbilical) result from surgical incision. Actually, there is no loss of tissue under these circumstances. The muscles of the abdominal wall have been deprived of the opportunity to oppose its opposite member, frequently for extended periods. The retracted muscle, along with scar tissue, becomes fixed and loses its resilience. If reapproximation is to be achieved, then considerable tension must be exerted upon the suture line. The general unattractiveness of suture lines under tension led to the development of many devices which were designed to serve as a patch for the defect and avoided the prospect of suture line tension. Among these were Tantalum mesh, stainless steel mesh, plastic screen and other materials. The general failure of this approach resulted from the development of several complications, among which were fragmentation of the patch material, development of infection and loss of fixation to the hernia ring. The latter complication was especially troublesome in my experience, being responsible for recurrence not infrequently in obese patients.

A successful repair must be characterized by two essential features. The reapproximation suture material must not break, and it must not cut through the muscle and fascia of the hernia ring. Such an ob-

The author, professor of surgery at the University Medical Center, writes about incisional hernias in this fifth of his series on problems in abdominal surgery. He discusses prevention, reasons for advising surgical correction, basic principles relating to a successful repair, and postoperative complications. An illustrative case is also presented.

From the Department of Surgery, University of Mississippi Medical Center, Jackson, MS.

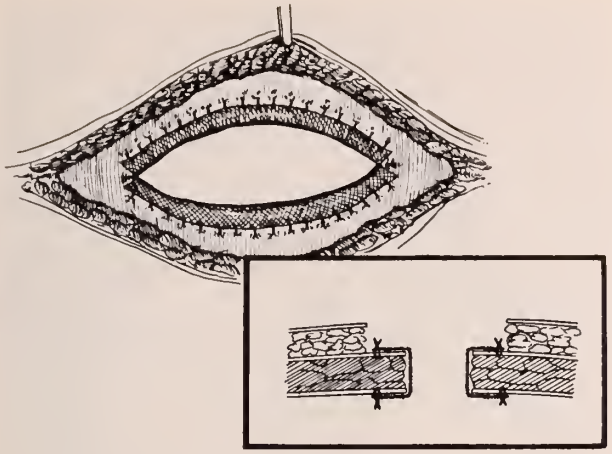


Figure 1. Marlex "backing" around hernia ring.

jective can be achieved by utilizing polypropylene suture material and marlex mesh for "backing" of the muscle and fascia edges (see Figure 1). Another valuable principle which has been extended to incisional hernia repair is the practice of overlapping the marlex-backed edges of the hernia ring, as in the Mayo Umbilical hernia repair (see Figure 2).

Postoperative Complications. Redundant skin edges must be trimmed away after approximation of the fascial edges but in spite of this practice and the tacking down of skin flaps to the underlying fascia, seromas may develop occasionally. They usually respond satisfactorily to intermittent aspiration. We have not found continuous suction applied to subcutaneous plastic tubes to be necessary. In six instances of incisional and groin hernia repair utilizing marlex backing, we have observed wound infections with the discharge of pus. In all instances the abscess responded to the usual methods of management, and in none was it necessary to remove the marlex. Respiratory problems are not uncommon after the repair of large incisional hernias, following the replacement of multiple intestinal segments and omentum into the abdominal cavity and the application of closure under considerable tension. The upward pressure on the diaphragm may be of such magnitude as to mechanically limit respiration. The usual measures must be employed to combat this problem and in all our cases the difficulty has been resolved by the third to fourth postoperative day. Postoperative gastrointestinal decompression must be effectively utilized in these patients to minimize respiratory insufficiency and suture line tensions.

ILLUSTRATIVE CASE

B. K., a 57-year-old obese female, was hospitalized because of an incisional hernia which had been present for approximately 20 years (see Figure 3). It involved the abdominal wall from just below the xyphoid to a short distance above the pubic. Virtually all abdominal viscera, including the intestine, omentum, liver and spleen were in the hernia sac. Indeed, the kidneys were pedicalized and residing in the hernia defect. Only the pancreas remained in its usual position. Progressive enlargement of the hernia over the years had rendered the patient almost a total invalid. The skin over the center of the hernia had thinned to the point of impending ulceration.

Under general anesthesia the edges of the fascial defect were dissected free. Marlex backing was applied and most of the abdominal viscera were reduced. However, it was apparent the total reduction of the large cecum, ascending and transverse colon into the abdomen could not be achieved. This part of the large bowel along with the massive omentum were resected and gastrointestinal continuity was established by primary anastomosis of the ileum to the sigmoid colon.

Marginal respiratory function during the postoperative period necessitated close attention for 4 days, but this progressively cleared as the abdomen expanded to accommodate the need of the enclosed viscera. She was discharged on the tenth postoperative day with a well healed incision (see Figure 4).

DISCUSSION

Our experience with this approach to incisional hernia now includes 15 such operations (see Table I). More than half of these patients had had from one to three previous, unsuccessful attempts at repair. Only one recurrence has been observed thus far. This involved a patient who necessitated dismanteling of the repair about 4 hours after surgery in order to arrest a small arterial bleeder in the omentum. Recurrence of the hernia was apparent before discharge from the hospital. Three months later the defect was again exposed. The marlex backing was firmly in place. The polypropylene su-

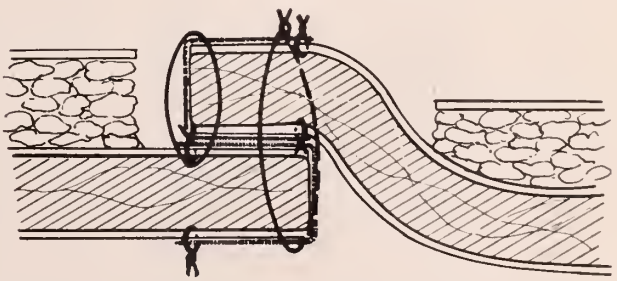
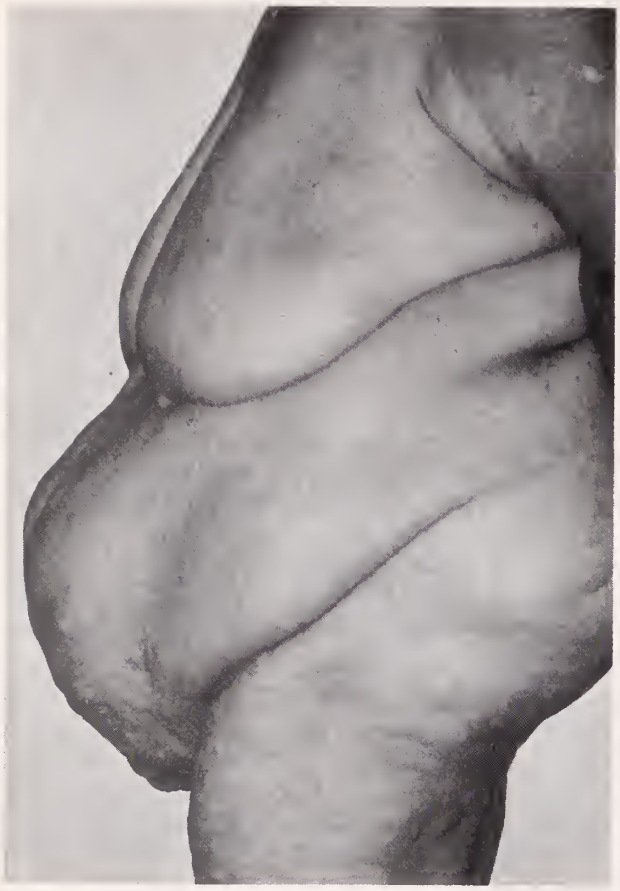


Figure 2. Final, overlapping fixation of abdominal wall muscle and fascia.





Figures 3 and 4. Pre and postoperative appearance after repair of large incisional hernia.

TABLE I

EXPERIENCES WITH THE REPAIR OF LARGE INCISIONAL HERNIAS

Case	*Sex*	*Previous Repairs*	*Site of Abdomen*	*Recurrence*
1. C.S.	M	3	Upper	No
2. J.J.	F	1	Lower	No
3. A.H.	F	0	Lower	No
4. B.K.	F	2	Both	No
5. C.H.	M	0	Upper	Yes*
6. V.P.	F	1	Lower	No
7. L.E.	F	1	Lower	No
8. N.G.	M	0	Upper	No
9. C.H.	M	1	Upper	No
10. E.L.	F	2	Lower	No
11. E.G.	M	2	Upper	No
12. O.W.	M	1	Lower	No
13. H.T.	M	0	Upper	No
14. M.B.	F	2	Lower	No
15. G.R.	M	0	Upper	No

* Knots in sutures apparently failed to hold—subsequently successfully repaired.

tures were lying free about the fascia. They had not broken or cut through the marlex-backed fascia, but had apparently come untied, as no knot could be observed. The patient is more than a year postoperative now, and without evidence of recurrence.

SUMMARY

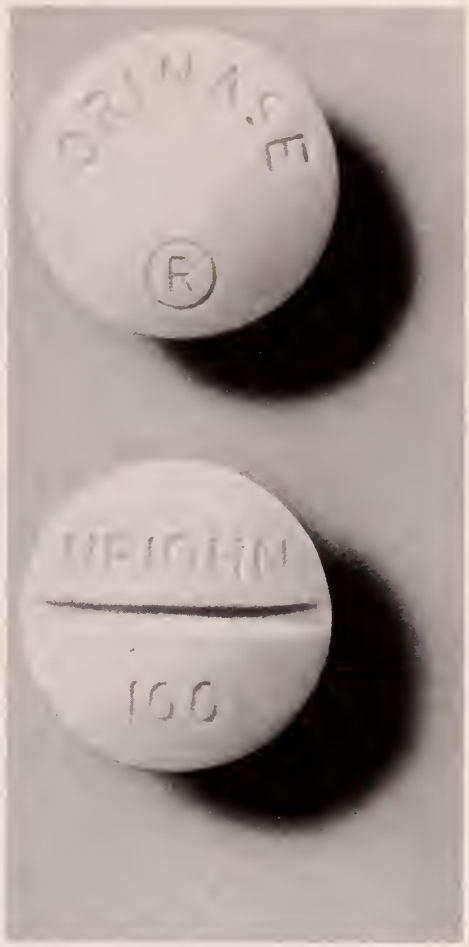
Most patients with abdominal incisional hernia merit surgical correction to the condition. The application of Marlex backing around the hernia ring with overlapping approximation of the edges, even under considerable tension, represents an improvement over the "patching" technique. Postoperative infections usually do not necessitate removal of the Marlex. It appears that the rate of successful repair can be improved by this approach. ★★★

2500 North State Street (39216)

REFERENCES

1. Barnett, W. O.: Etiology and Prevention of Abdominal Incisional Hernia. J. Miss. State Med. Assn. 1:367, 1960.
2. Usher, F. C.: The Repair of Incisional and Inguinal Hernias. Tex. Med. 67:106, 1971.

a new tablet design for



Orinase®
tolbutamide, Upjohn
0.5 Gm tablets



This new design will help pharmacists, physicians, nurses, and patients identify Orinase by name and manufacturer. The number on the tablet is for identification and is not related to tablet strength.

You may wish to advise your patients that this change is taking place.

J-5255-6

The Upjohn Company, Kalamazoo, Michigan 49001 **Upjohn**

©1976 The Upjohn Company

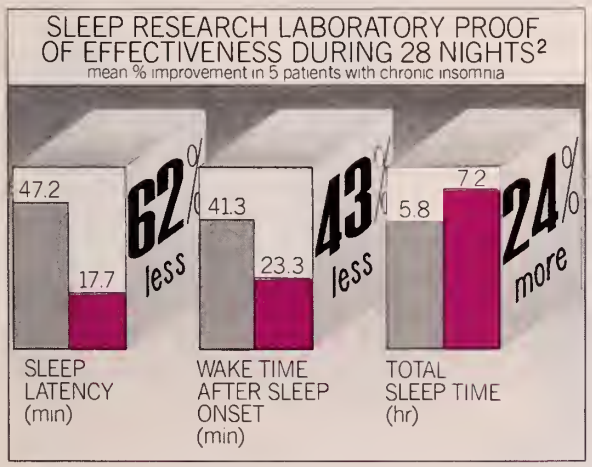

S
M
T
W
T
F
S
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

For insomnia that is a chronic problem...

Only Dalmane (flurazepam HCl) offers sleep laboratory proof of effectiveness for as long as 28 nights

Continued relief of insomnia in patients with chronic insomnia

Since insomnia is often transient and intermittent, the prolonged administration of a hypnotic is generally not necessary or recommended. But when insomnia is a chronic or recurring problem, continued effectiveness is as important as initial effectiveness. Results of a recently published sleep research laboratory study[1] demonstrated that, while pentobarbital lost effectiveness within two weeks, Dalmane maintained effectiveness for 28 consecutive nights. Similar 28-night results with Dalmane, displayed below, were obtained by a second sleep research group.[2] In previous studies,[3] both chloral hydrate and glutethimide began to lose effectiveness after several nights, while Dalmane maintained effectiveness throughout the 14 medication nights. Whether the problem is difficulty falling asleep, staying asleep or sleeping long enough, consider these results when selecting a sleep medication.



Patient benefits include relative safety, infrequent morning "hang-over"

Dalmane is well tolerated, seldom causing morning drowsiness or grogginess.[4] No increase in dosage is required for continued effectiveness from night to night.[1-3] Should Dalmane be used repeatedly, periodic blood counts and liver and kidney function tests should be performed. The usual adult dose is 30 mg *h.s.*, but 15 mg may suffice for some patients and is recommended as a starting dose for the elderly and debilitated to help preclude oversedation, dizziness or ataxia.

Continued relief of insomnia: One more good reason to specify

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.

whenever a hypnotic is needed

ROCHE

Please see following page for a summary of product information.

New objective proof: continued insomnia relief without increasing dosage...[1,2]

Dalmane® (flurazepam HCl) ℞IV

Objectively proved in the sleep research laboratory...

during 28 consecutive nights of administration:

- ☐ **effectiveness with a single 30-mg *h.s.* dose, maintained**
- ☐ **rapid sleep induction, maintained**
- ☐ **sleep for 7 to 8 hours, on average, maintained**
- ☐ **less time awake during the night, maintained**

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

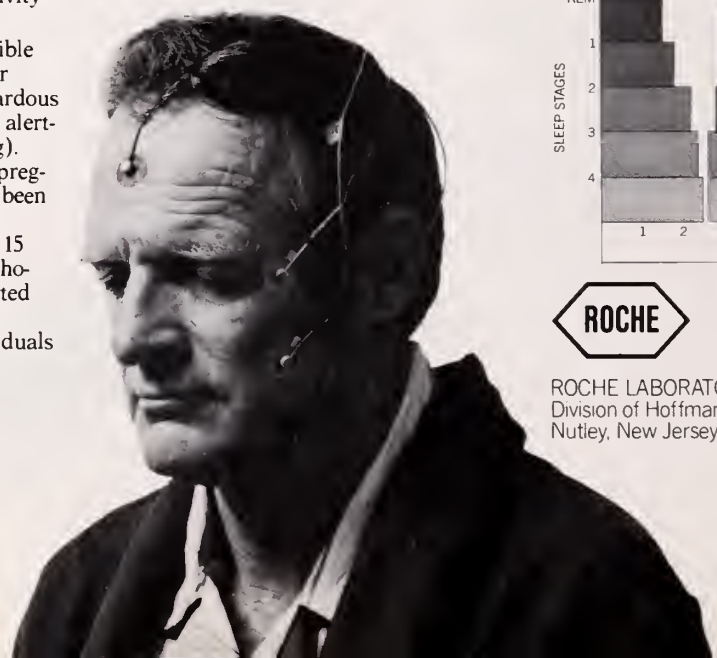
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

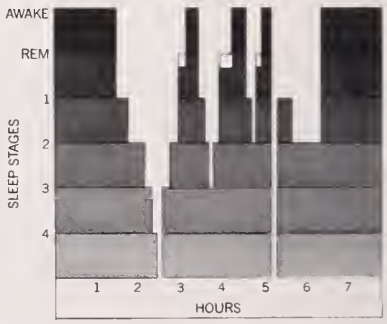
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



REFERENCES:

1. Kales A, *et al*: *Clin Pharmacol Ther* *18*:356-363, Sep 1975
2. Dement WC, *et al*: Long-term effectiveness of flurazepam 30 mg *h.s.* on chronic insomniacs. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, Jun 30-Jul 4, 1975
3. Kales A, *et al*: *Arch Gen Psychiatry* *23*:226-232, Sep 1970
4. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

For all common types of insomnia



ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Radiological Seminar CLXII: Liver Scanning in Polycystic Liver Disease

JANE A. SANDERS, M.D., and
W. MEL FLOWERS, JR., M.D.
Jackson, Mississippi

POLYCYSTIC LIVER disease is a rare congenital anomaly resulting in benign, progressive hepatomegaly. It can so closely mimic multiple metastatic foci on liver scan that differentiation between the two seems impossible. Clinical correlation, however, could lead one to suspect polycystic disease as the cause of the abnormal scan under the following circumstances:

1. Known or suspected polycystic kidney disease.
2. Hepatomegaly in a patient who has no known illness and has few or no clinical symptoms.
3. Normal liver function tests coexisting with a markedly abnormal liver scan.
4. An abnormal liver scan that remains stable over many years.
5. The sex and age incidences of this disease as described below.

There are two major forms of polycystic liver disease, the infantile and the adult. The infantile form is always associated with polycystic kidneys, is limited to children in the perinatal period, and is usually fatal in infancy or early childhood. It is regarded as an autosomal recessive and may reflect any one of four separate chromosomal aberrations. The adult form, in contrast, is an autosomal dominant, probably present in childhood but not becoming apparent until adult life. The reason for the gradual progressive enlargement of the cysts is unknown. The disease is more prevalent in women, with a ratio of approximately 4:1 females to males. It usually presents in the 4th to 8th decades of life. There is also a 5:1 ratio of whites to blacks.

The most frequent symptom is abdominal enlargement accompanied by a feeling of weight and fullness in the abdomen and occasional pain mimicking biliary colic. Physical examination reveals only hepatomegaly, ranging from minimal to marked, sometimes with a nodular or cystic feel to the surface of the liver.

Liver function studies are usually normal even when there is massive hepatic involvement. The cysts vary from few in number to virtual replacement of normal parenchyma. They predominate in the right lobe and vary in size from microscopic to large enough to hold one to two liters of fluid. The serous fluid is clear, yellowish to brown, and has a chemical composition similar to lymphatic or interstitial fluid, containing very little protein, bilirubin, glucose or enzymes. Although the exact mechanism of fluid formation is unknown, the chemical composition suggests that there is probably only a passive transfer of fluid into the cysts rather than active secretion.

Polycystic liver disease may occur as an isolated condition or it may occur in conjunction with polycystic kidney disease. Very rarely it is accompanied by cystic formation in other organs such as spleen, lungs, and pancreas. Pathogenesis is thought to be cystic dilation of persisting intralobular bile ducts which failed to involute in the late embryonic development of the liver.

The reported autopsy incidence of polycystic liver disease occurring in patients with polycystic kidney disease varies from 19-33 per cent while the incidence of polycystic kidney disease in patients with polycystic liver disease is about 50 per cent. In these patients where the two diseases coexist, it is the renal disease that determines the patient's clinical course.

Polycystic liver disease occurring as an isolated entity is rarely ever life-threatening. Treatment is reserved for those who have developed clinical symptoms and usually consists of surgical removal or unroofing of the cysts with fluid drainage. The cyst fluid is not irritating to the peritoneum.

Confirming the diagnosis without surgery requires careful evaluation and correlation of the patient's history, physical examination, and laboratory values. Recent reports indicate that ultrasound may be a valuable noninvasive procedure to aid in establishing

---

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, The University of Mississippi Medical Center, Jackson, MS.



Figure 1A. Anterior view of the liver. Three different photographic exposures of the same image emphasize the extreme variation in activity caused by countless cystic lesions. The liver is enlarged; the shape and contour are considerably distorted.



Figure 1B. Lateral view. Three different photographic exposures of the same image. Note that the differentiation from extensive metastatic carcinoma on the basis of the images alone is quite impossible.



Figure 2A. Anterior view of another example of polycystic liver disease. Three different photographic exposures of the same image demonstrate the severe distortion caused by the multiple focal lesions.



Figure 2B. Lateral view. Three different photographic exposures of the same image.

the diagnosis when multiple defects are found on the liver scan.

CONCLUSIONS

Polycystic liver disease presents as multiple areas of decreased activity on the liver scan. These may be easily mistaken for several other disease entities with far graver prognoses. The differential diagnosis includes multiple pyogenic or amebic abscesses, echinococcal cysts, and hemangioma; but, most important is the differentiation between polycystic disease and widespread multiple metastatic foci. Although polycystic liver disease is a rare abnormality, it is a benign condition that usually requires no treatment. It should always be considered when multiple cold defects are found on liver scans and clinical correlation can be decisive in the differential diagnosis. ★★★

2500 North State Street (39216)

REFERENCES

1. Lanson, S. Z., Frieden, J. H. and Bierman, H. R.: Polycystic Disease of the Liver. JAMA 215:793-4, Feb. 1, 1971.
2. Lieberman, E., Salinas-Madrigal, L., Gwinn, J. L., Brennan, L. P., Fine, R. N. and Landing, B. H.: Infantile Polycystic Disease of the Kidneys and Liver. Medicine 50:277-318, July 1971.
3. Longmire, W. P., Jr., Mandiola, S. A. and Gordon, H. E.: Congenital Cystic Disease of the Liver and Biliary System. Ann. Surg. 174:711-26, Oct. 1971.
4. Sanfelippo, P. M., Beahrs, O. H. and Weiland, L. H.: Cystic Disease of the Liver. Ann. Surg. 179:922-5, June, 1974.
5. Sanner, C. J. and Saltzman, D. A.: Polycystic Liver Disease—Report of a Case with Verification by Hepatic Sonography. JAMA 235: 1593-4, Apr. 12, 1976.

Regional Health Planning: What to Look For

THOMAS J. BROOKS, III
Jackson, Mississippi

SUFFICIENT TIME has now passed to allow for study of Public Law 93-641, the "National Health Planning and Resources Development Act of 1974," enacted into law Jan. 4, 1975. While provisions of the law are being subjected to public and private interpretations, important and potentially beneficial elements of its intricate but fundamentally sound concept are being overlooked or distorted in the current rush for state and areawide agency designation. P.L. 93-641 has been referred to by some as a multifarious agglutination of regulations which reel under their own collective weight. Perhaps this is so. It is the law, however, and probably contains some important positive features. Certain of its provisions are identified below.

THE PLUSSES

P.L. 93-641 seeks to establish the bases for developing regional *systems* of health care with emphasis on primary care services. Mississippi is in need of a better system of care, but system implies organization.

A System of Organization. There are currently no regional, integrated authorities for health care in Mississippi. *A regional authority should be responsible for the planning and delivery of health services for all persons within a defined geographic area.*[1] This should be an *official* regional authority under P.L. 93-641, the full governing board of which should be selected by a legislatively approved process.

A regional authority could identify specific needs, promote local and regional initiatives to meet those needs, and assist with financing. In the public health sector, numerous services are currently being delivered on a multicounty basis. These include family planning, nurse midwifery, and perinatology team care programs, in addition to home health services and a new plan for care of tubercular patients in selected regional hospitals. The experience of the State Board of Health has been that the organizing of services on a regional basis has generally resulted in better utilization of manpower and resources. While public health departments have traditionally been organized so as to provide team care for all persons needing it within a county or regional area,[2] and while they do have a local tax base, health departments have not been assigned the responsibility and authority for nonagency regionalization.

Conversely, areawide comprehensive health planning agencies, about which more discussion will follow, have had the exceedingly broad charge of planning for all parts of the health system and any aspect of physical, work, or personal environment. This charge has been so broad as to diffuse the energies of many CHP's throughout the United States.[3]

Primary Care. P.L. 93-641 attaches paramount importance to the achievement of better accessibility to care and lists as our first national health priority:

> "(1) The provision of primary care services for medically underserved populations, especially those which are located in rural or economically depressed areas."[4]

The law also emphasizes the need for construction of small primary/ambulatory care centers rather than inpatient facilities. Universal access to care at points closer to home so that Mississippians may remain in their local system of care, regardless of their ability to pay, has been recognized as a need in the state.

What about the status of physician manpower in Mississippi? From studies completed by the undersigned in 1973, it is evident that, since 1954, Mississippi physicians have been "urbanizing"* at a faster rate than the state's population as a whole. As of July 1, 1974, Hinds and Harrison counties had 36.9 per cent of the state's licensed, nonfederal physicians† and 15.9 per cent of the state's population for a ratio of one physician per 441 population. This compares with a ratio of one physician per 1,523 population in the rest of the state,[5] or about the

Director, Office of Planning and Evaluation, Mississippi State Board of Health, Jackson, MS.
The views expressed herein are those of the author and not necessarily those of the Mississippi State Board of Health.

* Urban is defined as any town with a population of 2,500 or more.
† This excludes any interns, residents, and physicians associated with state and federal agencies and institutions who did not have a Mississippi license (not compulsory for these personnel).

same as that in Peru.[6] Should this trend continue, and there is supposition that it may be abating, it will warrant concern since primary care physicians/generalists constitute the bulk of nonurban physician manpower.

Mississippi's Health Systems Agency, when finally made operational, should have the resources to identify for the private physician community areas of the state suitable for the strategic location of group practices. Another important HSA function should be to promote the utilization of nurse practitioners and other extended role personnel in public and private health care environs.

What Size Regional Planning Area? What constitutes a viable planning area is an important question. From all indications, boundaries of the 10 Economic Development districts, based on retail trade areas, constitute manageable regions.‡ While these regions should almost certainly not be reduced in size, some consolidation of them for purposes of Health Systems Agency designation under P.L. 93-641 has been and will continue to be a subject worthy of serious consideration.

P.L. 93-641, one would infer, is based on international experience with regional planning and is prescriptive on two issues:

1. The geographic size of regional *health services areas* must be in the 500,000-3,000,000 population range, unless otherwise specifically permitted by HEW.

2. Hierarchial delivery of services should be planned for, and one highly specialized center included in each region, if possible.[7]

Health Systems Agencies. Congress purposely created two thoroughly new types of health planning agencies, featuring cooperative ventures in each state between one autonomous State Agency for Health Planning and Development and multiple autonomous Health Systems Agencies. The two agencies differ in function and were designed to be countervailing forces.

Mississippi's one Health Service Area concept may work well if regional subcouncils are given broad latitude and authority and remain free of entanglements with local planning bodies in which health is only of peripheral interest. Presumptive evidence suggests, however, that with one Health Systems Agency and 10 subarea offices the role of the HSA central office (in Jackson, presumably) in relation to the State Health Planning and Development Agency may be unclear.

Consumer Participation and Local Control. It is self-evident that in Mississippi today citizen involvement in determining the availability and structure of medical care, on anything other than a superficial and perfunctory basis, is virtually nonexistent. This is not a desirable state of affairs in a democratic society which at the local level is becoming increasingly reliant upon federal government to understand the issues and prescribe and finance the remedy. The consumer cannot be expected to properly use the health care system without a more than rudimentary understanding of it. Involvement by interest groups is necessary and valuable but insufficient in and of itself. The health consumer in Mississippi has not been educated on matters relating to the structuring of health care services, but is rapidly gaining sophistication on the subject. The moment is approaching when adequate local funding for health projects will require elevation of consumer interest and awareness.

P.L. 93-641 provides for consumer and provider participation on governing boards of Health Systems Agencies and on the State Health Planning and Coordinating Council (SHCC). Local public initiative is important and should be nurtured in that it may serve to ensure a capability for responsiveness throughout the implementation of any plan for financing national health insurance.[8]

Financing Health Care. There *is* a problem with the financing of health care in Mississippi. For example, a recent check of a typical metropolitan health department's maternity program showed 96 women "to be delivered." Of this total, six had Medicaid and two had other insurance which would cover hospital delivery. If the remaining 88 have a median family income calculated to be $2,472, how can they afford the $1,200 it takes to have a baby?

In Mississippi and the United States, regional organization has slight historical precedent. Yet, the concept of regional financial participation in health care is not as unconventional as it sounds. While Mississippi's 10 Planning and Development Districts still do not have regional taxing authority, they do operate on revenues allocated by county governments. Based on traditional tax support levels, however, health care has not been of prime local concern. In 1973, Mississippi's 82 county governments spent over 12 times as much for "public works," the overwhelming majority of which was expended for the maintenance and operation of highways, as for health ($56.9 million to $4.5 million*).[9] Since good

‡ The Southern district actually represents two distinct catchment areas, the Hattiesburg-Laurel region and the "Coastal Zone" region.

health care is now being thought of as a broad community goal, Health Systems Agency and State Health Planning and Development boards both should reflect compelling representation by those who establish county priorities, local elected officials.

Under P.L. 93-641, proposed health facilities judged to be duplicative would not be authorized (certificate of need) and existing facilities judged to be unnecessary would be phased out. A recent report indicated that over 67,000 unneeded hospital beds would be in operation in the U. S. by 1975. This excess was estimated to cost the health consumer $1-2 billion per year.[10] According to the U. S. Public Health Service formula for relating acute general hospital beds to population, Mississippi is overbedded with 11,993 beds and a need for 10,274. Some areas still have a need, of course. Kerr L. White has demonstrated, however, that what is regarded as excess bed capacity may not be the major determinant of the use of hospitals; where the need for ambulatory care physicians is highest, hospitalization is also highest.[11]

Areawide Comprehensive Health Planning agencies have operated on the sensible notion that health financing should be closely related to health planning.[12] Capital expenditures, however, the review and control of which represented CHP's forte, represent only 3 per cent of the U. S. health dollar. The Partnership for Health legislation, P.L. 89-749 (CHP), may not, therefore, have incorporated the best strategy for reorganization of health services at the state and local levels.[13]

There are national figures available on the costs of medical care. In the February-March 1976 period, medical care prices continued to outstrip the overall Consumer Price Index (CPI), rising 1.1 per cent against 0.2 per cent for the general index.[14] This is not an ephemeral trend, the price of medical services having risen 1.5 times as fast as the CPI in the past 24 years.[15] Health care costs are also absorbing a higher percentage of consumers' income. The percentage of total private consumption expenditures going to medical care rose from 5.9 per cent in 1960 to 7.8 per cent in 1973. Per capita private expenditures for health services rose from $54.47 in 1950 to $281.95 in 1974. Hospital costs have led the surge, the cost of a semi-private room soaring 229 per cent between 1967 and April 1975, while operating room charges rose 235 per cent during that period.[16]

Many experts believe that inflation in the health care sector will continue to be of serious concern in future years. In order to garner further information on the behavior of medical care prices and their impact on the individual household and on society, the National Council on Wage and Price Stability has recently scheduled a series of public hearings throughout the country to begin on June 29.[17]

THE MINUSES

Looking Out for the Public Interest. Difficulties and disappointments arising from the development of Health Systems Agencies have related more to the process of agency selection than to the law itself. In the other eight DHEW Region IV states, there have not been competing applications for HSA designation. Where there has been competition elsewhere in the nation, however, the ensuing maelstrom has been destructive of the public trust. It is not in the public interest in any state for federal and state agencies and elected officials to allow a climate to develop in which competing forces are allowed to set upon one another and in which the survivor is ultimately declared the "winner" and HSA designee. New York foresaw the potential harm in this situation, and, where there was evidence of competing parties, "Blue Ribbon" panels were established to oversee the development of HSA applications and boards.

Nonprofit Corporations. Vincente Navarro of Johns Hopkins University has captured the thrust of apprehension concerning autonomous nonprofit private corporations and has expressed the view that the planning and regulation of health services, private and public, should be in the public sector, following federal, state, and local structures of our system of government. Navarro would strengthen, democratize, and revitalize the normal political machinery of our government and not weaken it by bypassing the levels of government. He states:

> "In a time of increasing popular alienation from public institutions,* there is a need for encouraging, not discouraging, the involvement of the citizenry in the selection of social priorities and the allocation of resources . . . [and] it has been shown that public corporations like the New York Port Authority, which are autonomous and independent of democratic control, tend to be unresponsive to public needs and demands when these conflict with the corporations' financial interests. . ."[18]

* These two sums include operating and non-capital outlay expenditures only. Approximately one-third of the $56.9 million and 90 per cent of the $4.5 million were generated from county ad valorem taxes.

* See "Confidence in Key U. S. Institutions," *The Gallup Opinion Index*, Report No. 97, July, 1973, pp. 10-17.

Much discussion has focused on the composition of HSA governing boards. While the question of who board members are is an important one, the decisive issue is how they are chosen. P.L. 93-641 makes no stipulation about how board members are to be selected. In the personal opinion of the writer, any inherent risks which may accrue from the use of nonprofit private corporations may be neutralized if, in Mississippi, consideration will be given to statutorially specifying that HSA governing board members are to be 1) appointed by elected officials, specifically, presidents of county boards of supervisors and mayors, or 2) popularly elected or selected by a predetermined process.

CONCLUSIONS

P.L. 93-641 seeks to establish the bases for developing regional systems of care with emphasis on primary care services. This is to be accomplished by way of a regional-influence Health Systems Agency with planning and implementation responsibilities. Heretofore, there have existed at the state, regional, and local levels planning bodies with authority and dimension insufficient for coming to terms with a multidirectional health care apparatus. In financing, the notions of achieving better and more health care will continue to imply community and community/governmental responsibilities beyond simple cost/sharing.

Probably all modern substantive issues in health care will be decided by providers in concert with a more active and inquisitive consumer and elected official constituency. Hopefully, P.L. 93-641 will provide the avenue for expanded cooperation between these groups. ★★★

P.O. Box 1700 (39205)

REFERENCES

1. Berfenstam, Ragnar and Elling, Ray H.: Regional Planning in Sweden: A Social and Medical Problem, appearing in Health Care in Scandinavia. Reproduced from Scandinavian Review, No. 3, 1975, by the Geographic Health Studies Program, John E. Fogarty International Center for Advanced Study in the Health Sciences. Washington: Department of Health, Education, and Welfare, 1975, pp. 40-52. A skillful discussion of regional health planning in Sweden, ideally and operationally.
2. Berfenstam and Elling, p. 52.
3. U. S. Congress, Committee on Labor and Public Welfare: National Health Planning and Development and Health Facilities Assistance Act of 1974, 93rd Cong., 2d Sess., 1974, S. Rept. 93-1285 to accompany S. 2994, pp. 5-13.
4. U. S. Congress, National Health Planning and Resources Development Act of 1974, Public Law 93-641, 93rd Cong., 2d Sess., 1974, Section 1511, p. 4.
5. Mississippi State Board of Health, Statistical Services: Unpublished Data.
6. U. S. Department of Health, Education, and Welfare, Public Health Service, Health Resources Administration, National Center for Health Statistics: Health Statistics: 1975, p. 110.
7. Public Law 93-641, p. 6.
8. MacLeod, Gordon K.: Critical Commentary on Consumerism in Denmark and the U. S. Health Care in Scandinavia, pp. 26-27. The Danish experience has demonstrated that local consumer boards serve to reduce dependency on government and are effective in promoting public awareness of the need for new health services.
9. County Receipts and Disbursements and Bonded Debt for the Fiscal Year Ended September 30, 1973, A Report Submitted to the Governor and Legislature of Mississippi by the State Department of Audit. Jackson, Mississippi, State Department of Audit, 1973, pp. 5-18.
10. Senate Report 93-1285, p. 39 and p. 42.
11. White, Kerr L.: International Comparisons of Medical Care. Scient. Am., 233:23, August, 1974.
12. Senate Report 93-1285, p. 7.
13. Navarro, Vincente: A Critique of the Present and Proposed Strategies for Redistributing Resources in the Health Sector and a Discussion of Alternatives. An Invited Paper in the Community Health Planning Section of the 101st Annual Meeting of the American Public Health Association, San Francisco, California, November 4-9, 1973, p. 16.
14. Briefly This Week. Washington Report on Medicine and Health, April 26, 1976, p. 4.
15. Marmer, Theodore R., Whitman, Donald A. and Heagy, Thomas C.: The Politics of Medical Care Inflation. Center Report, IX (3): 20-21, 1976.
16. Cambridge Research Institute for the U. S. Department of Health, Education, and Welfare: The Cost to the Consumer of Health Care. Trends Affecting the U .S. Health Care System, Washington, U. S. Government Printing Office, 1976, pp. 157-160.
17. Council on Wage and Price Stability. Federal Register, June 3, 1976, p. 22407.
18. Navarro, p. 19.

Merger: C of C and NAM . . . worried over the growing anti-business attitudes in Congress the U. S. Chamber of Commerce and the National Association of Manufacturers have agreed to merge in a move to build up their forces in Washington.



The President Speaking

"Health Care Regulation"

LYNE S. GAMBLE, M.D.
Greenville, Mississippi

AMONG THE guest speakers at the recent meeting of the American Medical Association were: Dr. Harry P. Cain, acting director, Bureau of Health Planning and Resource Development, H.E.W., Washington, D. C.; The Honorable Jim Wright, Congressman, 12th district, Texas, member, Committees on Budget, Government Operations, Public Work and Transportation and The Honorable Marjorie Lynch, Under-Secretary of H.E.W.

Mrs. Lynch, who served a year as the state president of the Women's Auxiliary to the Washington State Medical Society, assured us of her own personal commitment as well as that of Secretary Mathews and Dr. Ted Cooper to opening up the department and giving the medical profession more of an opportunity to work with the Department of Health, Education, and Welfare. Mrs. Lynch covered a number of topics. She described the President's efforts to get away from the categorical grant approach by requests for block grants to states for health, education, and social services thereby restoring the determination of priorities to the local level. In considering the rising costs of medical care, she discussed the role of increasing technology and of overutilization on the part of patients and warned that if costs are not contained, Congress, because of public pressure, will invade this area more and more. In discussing fraud and abuse of federally funded health care programs like Medicare and Medicaid, she emphasized very strongly that the percentage of health care professionals involved is very small but that they are harming the image of the thousands of dedicated men and women who serve in the health field.

Dr. Cain limited his remarks to the Health Planning Act and its implementation. He stated that the aim of the act was to establish community based planning. Or, as he put it, "to add reason to regulation." He outlined the targets of the act as: (1) To assure access to health care, (2) To rationalize resource allocation within this industry in order to control costs, and (3) To improve health. He stated that the scope of the act ranged from health, education, and environmental-occupational health to long term care and stated that the promise of the planning effort is that it can help assure that regulatory decisions regarding institutional facilities and services are reasonable, reasonable in this context being consistent with community planning in which all parties have had their say. In his progress report, Dr. Cain noted that appropriations to date have been inadequate to the task and it is anticipated that appropriations will be increased. He stated that

(Continued on page 276)

suits are being brought challenging the constitutionality of the planning act, the areas designated, and the agencies chosen. It was his opinion that some items in the act were inadvisedly written and will require some change. He stated that the authority of the act expires in 1977, so Congress will have to decide whether to extend it at that time. He noted that although there is dissatisfaction with some of the provisions of the act in Washington, there is great support for the concept of health planning.

The Honorable Jim Wright was 31 years of age when he was first elected to Congress. Since that time, he has served 11 consecutive terms in the House of Representatives. He noted that the growth of the tendency of government to regulate seems to coincide with the inexorable growth of the appointed bureaucracy. During the time that the population increased 75 per cent, the number of federal appointees in the civilian branch of government increased almost 600 per cent. The people increasingly find their lives regulated not by statutes enacted by their duly elected representatives, but by regulations written by people that they don't know, have not elected, and can not remove. In instances in which the regulations are clearly not in accord with the intent of the law redress by legislation has been possible. This is a slow process. Other remedies to the situation discussed by Mr. Wright are: the return of the decision making process to the local level, the inclusion in legislation of a provision requiring periodic affirmative action by Congress to extend the life of the legislation, and a process by which all regulations would be submitted to the parent committee of Congress that created the legislation in the first place. Mr. Wright is indeed an articulate analyst of the bureaucratic structure.

All in all it was a very informative meeting. I was impressed by the problems of health care cost containment expressed by the several speakers. As a physician, however, I feel that we must be primarily concerned with maintaining and increasing medical excellence. ★★★

TAX BITES, STATE BY STATE: WHAT ONE STUDY SHOWS

How much do you pay in state and local taxes when you add up income, sales, property, motor-vehicle and other levies? Stephen E. Lile, an associate professor of economics at Western Kentucky University, calculated taxes paid by hypothetical families in the largest cities in the 48 contiguous states. His results—using 1974 figures—as published by the Council of State Governments are:

	Family With $10,000 Income	*Family With $25,000 Income*		*Family With $10,000 Income*	*Family With $25,000 Income*
Alabama	$ 815	$1,809	Nebraska	$ 902	$1,954
Arizona	768	1,772	Nevada	551	1,007
Arkansas	700	1,711	New Hampshire	816	1,591
California	875	2,274	New Jersey	1,443	2,905
Colorado	950	2,225	New Mexico	738	1,699
Connecticut	1,234	2,460	New York	1,059	2,878
Delaware	833	2,365	North Carolina	898	2,199
Florida	492	863	North Dakota	783	2,128
Georgia	784	2,081	Ohio	787	1,824
Idaho	777	2,143	Oklahoma	640	1,607
Illinois	1,071	2,230	Oregon	835	2,338
Indiana	964	2,029	Pennsylvania	1,152	2,485
Iowa	1,208	2,638	Rhode Island	1,045	2,334
Kansas	1,050	2,335	South Carolina	730	1,930
Kentucky	903	2,094	South Dakota	878	1,646
Louisiana	462	932	Tennessee	717	1,291
Maine	971	2,084	Texas	612	1,153
Maryland	1,282	2,985	Utah	815	2,027
Massachusetts	1,391	3,258	Vermont	1,035	2,503
Michigan	883	2,151	Virginia	792	1,950
Minnesota	1,212	3,006	Washington	676	1,179
Mississippi	658	1,183	West Virginia	563	1,220
Missouri	930	2,126	Wisconsin	1,476	3,672
Montana	918	2,211	Wyoming	580	1,069

Note: Study assumes all families own an automobile and a home: families with $10,000 income, houses worth $20,000; families with $25,000 income, houses worth $43,750.

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, June 26-July 1, Dallas. Clinical Convention, Dec. 4-8, 1976, Philadelphia. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

La.-Miss. O. and O. Society, April 28-May 1, 1977, Point Clear, Ala. Arthur Hays, M.D., Secy., 3017 13th St., Gulfport 39501.

STATE AND LOCAL

Mississippi Academy of Family Physicians, Annual Meeting, July 7-10, 1976, and July 6-9, 1977, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 109th Annual Session, May 2-5, 1977, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Smith, Yazoo.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Gerald A. Smith, Secy., P.O. Box 128, Sumner 38957. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. A. K. Martinolich, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Reginald P. White, Secy., East Mississippi State Hospital, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, April, June, August, October, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., Jefferson Davis Memorial Hospital, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. D. Stanley Hartness, Jr., Secy., 314 Adams St., Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Lee H. Rogers, Secy., 610 Brunson Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, October. Cherie Friedman, Secy., 1004 Jackson Ave., Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. James H. Sams, Secy., P.O. Box 1381, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, May, July, September, November. Dewey Laner, Secy., Doctors Plaza, Suite 206, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. John L. Smith, Secy., No. 1 Medical Blvd., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

When the same patient makes your office a merry-go-round of somatic complaints



Adapin® (doxepin HCl) may be what she needs

I'm so jumpy, I'm afraid of my own shadow.

I have these headaches almost everyday—I can't understand it, I never used to have them.

Doctor, is it right that I should be so constipated all the time?



Anxiety/depression could be the basis of her somatic complaints
You know the type. She's got a new symptom every visit. And there's never any physiological basis. When you see the chronic "complainer," a diagnosis of depression may be considered... and an Rx for Adapin.

Adapin allays anxiety; improves sleep; brightens the outlook
Adapin can often help the chronic "complainers" get positively re-involved with life. Adapin almost immediately allays symptoms of anxiety and tension. And from the earliest days it makes it easier for the patient to get to sleep—helps her stay asleep longer. And where there is underlying depression, Adapin usually begins to lift it within three or four weeks.

Please see following page for prescribing information

ADAPIN®
(Doxepin HCl)
Capsules, 10 mg, 25 mg and 50 mg

PENNWALT

ADAPIN®
(Doxepin HCl)



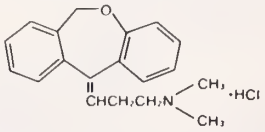
10 mg. **25 mg.** **50 mg.**

Usual optimum dosage is 75 to 150 mg. per day.

Prescribing information:

DESCRIPTION

Adapin (doxepin HCl) is an isomeric mixture of N, N-dimethyl-dibenz(b,e) oxepin- $\Delta^{11(6H)}$, γ propylamine hydrochloride.



ACTIONS

Adapin has a variety of pharmacological actions with its predominant action on the central nervous system. While its mechanism of action is not known, studies have demonstrated that it is neither a monoamine oxidase inhibitor nor a primary stimulant of the central nervous system.

INDICATIONS

In controlled clinical evaluations, **Adapin** has shown marked antianxiety and significant antidepressant effects. **Adapin** has been found to be well tolerated even in elderly patients.

Adapin is indicated for the treatment of patients with:

1. Psychoneurotic anxiety and/or depressive reactions.
2. Mixed symptoms of anxiety and depression.
3. Anxiety and/or depression associated with alcoholism.
4. Anxiety associated with organic disease.
5. Psychotic depressive disorders including involutional depression and manic-depressive reactions.

Target symptoms of psychoneurosis that respond particularly well to **Adapin** include: anxiety, tension, depression, somatic symptoms and concerns, insomnia, guilt, lack of energy, fear, apprehension and worry.

Because **Adapin** provides antidepressant as well as antianxiety effects, it is of particular value in patients in whom anxiety masks depression. Patients who have not responded to other antianxiety or antidepressant drugs may benefit from **Adapin.**

In a large series of patients systematically observed for withdrawal symptoms, none were reported—a finding which is consistent with the virtual absence of euphoria as a side effect and the lack of addictive potential characteristic of this type of chemical compound.

CONTRAINDICATIONS

Because **Adapin** has an anticholinergic effect, it is contraindicated in patients with glaucoma or a tendency toward urinary retention.

Use of **Adapin** is contraindicated in patients who have been found hypersensitive to it.

WARNINGS

Usage in Pregnancy—Adapin has not been evaluated in pregnant patients. Therefore, it should not be used during pregnancy unless, in the judgment of the physician, it is essential to the welfare of the patient.

In animal reproduction studies of **Adapin,** gross and microscopic examination of the offspring gave no evidence of drug-related teratogenic effect. Following doses of up to 25 mg./kg./day for 8 to 9 months, no changes were observed in the number of live births, litter size, or lactation. A decreased rate of conception was observed when male rats were given 25 mg./kg./day for prolonged periods—an effect which has occurred with other psychotropic drugs and has been attributed to drug effect on the central and/or autonomic nervous systems.

Usage in Children—The use of **Adapin** in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors—Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with **Adapin.** The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

PRECAUTIONS

Drowsiness may occur with **Adapin (doxepin HCl);** therefore, patients should be warned of its possible occurrence and cautioned against driving a motor vehicle or operating hazardous machinery while taking the drug.

Patients should also be cautioned that the effects of alcoholic beverages may be increased.

Since suicide is an inherent risk in depressed patients and remains a risk through the initial phases of improvement, depressed patients should be closely supervised.

Although **Adapin** has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Compounds structurally related to **Adapin** can block the effects of guanethidine and similarly acting compounds. However, at the usual clinical dosages, 75 mg. to 150 mg. per day, **Adapin** has been given concomitantly with guanethidine without blocking its antihypertensive effect. But at dosages of 300 mg. per day or higher, **Adapin** has exerted a significant blocking effect.

Adapin, like other structurally related psychotropic drugs, potentiates norepinephrine response in animals. But this effect has not been observed with **Adapin** in humans, which is in accord with the low incidence of tachycardia reported clinically.

ADVERSE REACTIONS

Anticholinergic Effects: Dry mouth, blurred vision and constipation have been reported. These are usually mild, and often subside as therapy is continued or dosage reduced.

Central Nervous System Effects: Drowsiness has been observed. It usually occurs early in the course of therapy and tends to subside as therapy continues. (See Dosage and Administration section.)

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported adverse effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects (such as increased sweating), weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

DOSAGE AND ADMINISTRATION

In most patients with mild to moderate anxiety and/or depression: 10 mg. to 25 mg. t.i.d. to start. A starting dosage of 10 mg. t.i.d. for a period of four days may reduce the initial drowsiness experienced by some patients, and may be tried in cases where drowsiness is clinically undesirable. Decrease or increase the dosage at appropriate intervals according to individual response. Usual optimum dosage is 75 mg. to 150 mg. per day.

In some patients with mild symptomatology or emotional symptoms accompanying organic disease, dosage as low as 25 mg. to 50 mg. per day has provided effective control.

In more severe anxiety and/or depression: 50 mg. t.i.d. may be required to start—if necessary, gradually increase to 300 mg. per day. Additional effectiveness is rarely obtained by exceeding 300 mg. per day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

OVERDOSAGE

Symptoms—An increase of any of the reported adverse reactions, primarily excessive sedation and anticholinergic effects such as blurred vision and dry mouth. Other effects may be: pronounced tachycardia, hypotension and extrapyramidal symptoms.

Treatment—Essentially symptomatic; supportive therapy in the case of hypotension and excessive sedation.

HOW SUPPLIED

Each capsule contains doxepin, as the hydrochloride: 10 mg. (NDC 0018-0356), 25 mg. (NDC 0018-0357) and 50 mg. (NDC 0018-0358) capsules in bottles of 100, and 1000.

Brighter days ahead for your psychosomatic complainers



PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XVII, NUMBER 9
SEPTEMBER 1976

EDITORIALS

Can We Afford National Health Insurance?

In the early thirties doctors usually discussed with the patient the necessity for, and cost of, such simple procedures as blood counts, chest x-rays, and blood chemistry before they were performed. At that time third party payments were virtually nonexistent. Hospital admissions were limited to the very ill and those in need of surgery, and both the physician and hospital had every incentive to keep costs at a minimum, that is, the insistence of the patient. Charges were frequently based on the ability to pay, particularly anything more than a routine office or house call. Those unable to pay and in need of care were treated as charity. Well care and preventive medicine were at a minimum. The total health care, in cost, was insignificant as a factor in national industry. I do not contend, however, that these were "the good old days."

Today a large segment of society, those below "poverty level," are usually on medicaid. Their medical care is totally covered; medical care is overutilized and there are practically no limitations to the extent of care provided. Another large segment is covered by private insurance either through group policies or individual policies. These have more limitations and usually do not cover "routine" office calls and most of the time have some limitations of hospital benefits for one illness. A third and growing segment is covered by medicare and while it has many more limitations than medicaid, it also is pretty comprehensive in its coverage. The first two of these groups have little concern with the cost of care and as a result neither the doctors nor hospitals have much incentive to limit costs. The third group shares some financial responsibility but probably this factor accounts for little toward deterring rising medical costs. Third party payment then, in the opinion of this writer, is the biggest factor in the rising costs of medical care. Third party payment is here to stay and we must look elsewhere for solutions. Certainly advanced technology is in part responsible for increased costs. Cardiovascular surgery, renal dialysis, and advanced costly laboratory procedures are principal factors but also such things as the increased use of endoscopy with flexible scopes may be appreciable both in physicians' time and expensive equipment.

With this experience in mind, the idea that the government can insure total health care for all seems to this writer ridiculous. Where the bureaucracy attempts to place the blame on "greedy" doctors and poorly administered hospitals, let them be reminded that the average outpatient visit in the veterans administration system costs $50.00.

We had best pause, examine our present state, set priorities and limitations for what we are now subsidizing before blundering into an even worse situation.

W. Moncure Dabney, M.D.
Editor
Crystal Springs, MS

Editorial Comment on Scientific Article

The review of herpes type 2 (genital herpes) published in this issue is both timely and interesting as we now know that this is a significant disease in the newborn and that with a little foresight most neonatal infections can be prevented.

Neonatal herpes is usually acquired during transvaginal passage in the mother with a primary active genital herpes infection. It has been reported as a transplacental infection with the virus cultured from the amniotic fluid, but this is apparently very rare.[1] In neonates with a delayed onset (6 weeks) of symptoms, a nosocomal (hospital acquired) infection acquired in the nursery either from personnel or another infected baby must also be considered.[2]

Sever, in a recent teratology course, made several excellent points:

1. The problem is at term with a primary genital infection. Repeat infections with the same virus seem to place the infant at low risk.

2. Nursery personnel with recurrent herpes infection should not work in the nursery and probably not in obstetrics. (They should also not work with patients on immunosuppressive therapy.)

3. In the patient with active primary disease in whom delivery is necessary, and membranes either intact or ruptured for a short time (four to six hours would seem to be an acceptable compromise—DMS), cesarean section is the preferred method of delivery.

It would seem logical that since the problem is at term, and then only with primary infections with the herpes present, routine speculum examination of the vagina and cervix with cytological (Pap) examination should be carried out at 37-38 weeks. If positive for herpes, cesarean section should be used for delivery if labor or rupture of the membranes occurs within three weeks.

Prevention of neonatal herpes is important as 90 per cent of neonates with systemic disease will die and the rest will be severely effected. Neonatal therapy at this time is only satisfactory in about half of the cases it has been tried on.[3]

DONALD M. SHERLINE, M.D.
Department of Ob-Gyn
University Medical Center
Jackson, MS

REFERENCES

1. Kaufman, R. H.: Herpesvirus Infection of the Genital Tract—A Symposium. Contemporary Ob.-Gyn. 6:122, July, 1975.
2. Francis, D. P., et al: Nosococomal and Maternally Acquired Herpesvirus Hominis Infections. Am. J. Diseases of Children 129:889-893, August, 1975.
3. Sever, J. L.: Teratology Course. Snowmass, Colorado, August, 1975.

Medico-Legal Briefs

ILLINOIS PHYSICIAN WINS COUNTERSUIT

In a landmark decision, a radiologist was awarded $2,000 in compensatory damages and $6,000 in punitive damages by an Illinois jury.

The radiologist, an orthopedic surgeon, and a hospital were named as defendants in a malpractice suit. The patient and her husband sought $250,000 in damages claiming that the defendants failed to discover a fracture in the patient's little finger and that as a result the finger has a lasting disability. The patient, who had injured her finger while playing tennis, claimed that the radiologist misread the hospital x-rays. The fracture was discovered in subsequent x-rays.

In the radiologist's countersuit against the patient, her husband, and their two attorneys, the radiologist contended that the fracture did not appear on the first x-rays, through no negligence on his part or on the part of the hospital. He said that the treatment given the patient was the same as that given for a fracture.

Both the malpractice suit and the countersuit were to be tried together. The day after the jury was selected, the patient and her husband withdrew their malpractice suit. The radiologist continued with his suit, however. The orthopedic surgeon and the hospital did not join in the countersuit.

In his complaint, the radiologist charged that all four of the defendants were "guilty of willful and wanton conduct." He also contended that the attorneys were "negligent in fulfilling their duties as attorneys in investigating the malpractice suit before filing it."—*Berlin v. Nathan* (Ill.Cir.Ct., Cook Co., Docket No. 75-M2-542, June 1, 1976)

NEW MEMBERS

BATES, GAYLON M., Columbus (Associate Member). Born Ethridge, TN, Dec. 27, 1939; M.D., University of Tennessee School of Medicine, Memphis, 1971; internship and pediatric residency, Kees-

ler AFB, Biloxi, MS, 1972-75; elected by Prairie Medical Society.

Blake, Thomas H., Jr., Laurel. Born Jackson, MS, Mar. 11, 1943; M.D., Tulane University School of Medicine, New Orleans, LA, 1968; interned City of Memphis Hospitals, one year; surgery residency, Methodist Hospital, Memphis, TN, 1969-73; Residency (Ortho Surg) Campbell's Clinic, Memphis, TN, 1973- ; elected by South Mississippi Medical Society.

Blumenthal, Bernard I., Jackson. Born Trenton, NJ, Jan. 11, 1938; M.D., University of Mississippi School of Medicine, Jackson, MS, 1965; interned Mercer Hospital, Trenton, NJ, one year; residency in radiology, The Graduate Hospital, University of Pennsylvania, 1968-71; pediatric radiology residency, St. Christopher's Hospital for Children, 1971-72; elected by Central Medical Society.

Byars, Wilton V., II, Greenville. Born Oxford, MS, Oct. 30, 1938; M.D., University of Mississippi School of Medicine, Jackson, 1966; interned UMC, Jackson, MS, one year; ob-gyn residency, same, 1967-70; elected by Delta Medical Society.

Clark, William F., Clarksdale. Born Houston, MS, Sept. 8, 1940; M.D., University of Mississippi School of Medicine, Jackson, 1970; interned UMC, Jackson, MS, one year; radiology residency, same, 1971-74; elected by Clarksdale and Six Counties Medical Society.

Cranston, Philip Edwin, Jackson. Born Mansfield, LA, July 9, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1970; internship and radiology residency, UMC, Jackson, 1970-74; elected by Central Medical Society.

Dahlke, Charles B., Columbus. Born Birmingham, AL, Oct. 17, 1942; M.D., University of Alabama School of Medicine, Birmingham, 1968; interned Mobile General Hospital, Mobile, AL, one year; radiology residency, University of Alabama, 1969-70 and 1972-74; nuclear medicine residency, same, 1974-75; elected by Prairie Medical Society.

Howe, Michael, Starkville. Born St. Louis, MO, Aug. 27, 1941; M.D., University of Tennessee School of Medicine, Memphis, 1966; interned Carraway Methodist Hospital, Birmingham, AL, one year; ob-gyn residency, University of Tennessee, Memphis, 1967-70; elected by Prairie Medical Society.

Jones, Walter R., Jr., Jackson. Born Greenwood, MS, July 21, 1941; M.D., University of Mississippi School of Medicine, Jackson, 1966; internship and surgery residency, UMC, Jackson, 1966-71; elected by Central Medical Society.

Jordan, Covin M., Jr., Grenada. Born Crossett, AR, Aug. 16, 1941; M.D., University of Arkansas, School of Medicine, Little Rock, 1967; interned St. John's Hospital, Tulsa, OK, one year; radiology residency, Baptist Medical Center, Little Rock, AR, 1970-73; elected by North Central Medical Society.

Westbrook, Terry E., McComb. Born Memphis, TN, Oct. 7, 1944; M.D., University of Tennessee School of Medicine, Memphis, TN, 1970; interned Naval Hospital, Boston, MA, one year; elected by South Central Medical Society.

LETTERS

Sirs: I am interested in finding the incidence of allergic reactions to chocolate because of a recent query I received from a chocolate manufacturer.

I would appreciate hearing from physicians the estimated number of their patients allergic to chocolate, and the symptoms produced. I would also appreciate receiving specific case reports, results of laboratory tests, and any other comments on the subject.

Claude A. Frazier, M.D.
Doctors Park—Bldg. 4
Asheville, NC 28801

Sirs: Some 40 special immunobiologic agents and drugs are distributed by the Center for Disease Control (CDC). These will be dispensed to requesting physicians for administration along with information about reactions, toxicity, etc.

These are the special preparations which are available:

Antitoxins and Antivenin

Botulinum equine antitoxin, diphtheria antitoxin and coral snake antivenin.

Globulins and Plasmas

Vaccinia immune globulin (human), Western equine encephalitis immune globulin (human), zoster immune globulin (human) and immune plasmas for therapy of unusual viral infections (Lassa fever, etc.).

Drugs for Parasitic Diseases

Niclosamide and pentamidine isethionate.

Skin Test Antigen

Tularemia skin test antigen.

Vaccines

Anthrax vaccine, absorbed; botulinum toxoid, pentavalent (ABCDE); Eastern equine encephalitis; tularemia vaccine, live, attenuated; Venezuelan equine encephalitis vaccine, live attenuated.

To obtain any of these, call 404-633-3311 (days) or 404-633-2176 (weekends and after working hours).

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health

PERSONALS

AFZAL AHMED has opened his office, Terry Medical Center, on N. Utica Street in Terry. His associate will be DEMETRA KARATHANASIS.

JUAN R. AMELL has associated with JOHN D. WOFFORD in the practice of internal medicine at 202 W. Park Avenue in Greenwood.

J. PHILLIP BALASKI has associated with CHARLES A. HOLLINGSHEAD and MICHAEL R. CASEY in the Laurel Medical and Surgical Clinic for the family practice of medicine at 103 S. 12th Avenue.

GEORGE BALL of Jackson has been elected section chairman-elect of the American College of Ob-Gyn and RICHARD S. HOLLIS of Amory is section vice chairman-elect for Mississippi.

MICHAEL DE BERARDINIS has set up his practice of urology at Doctors' Park offices in Houston.

DARRELL N. BLAYLOCK announces the opening of his new office at 130 E. Walker Street in Greenville.

DAVID W. BOMBOY has associated with W. G. GILES, J. STEWART WILLIFORD and THOMAS J. DEWEY, III, of Hattiesburg for the practice of orthopedic surgery at The Orthopedic Clinic, P.A., #7 Medical Boulevard.

BRUNER B. BOSIO has associated with the Obstetrics Gynecology Infertility Association, P.A., for the practice of obstetrics and gynecology at the Doctors' Plaza, Suite 208, Pascagoula.

JOHN W. BOWLIN and FRANK A. NICHOLS of Tupelo announce the limiting of their practice to thoracic and cardiovascular surgery at 810 Garfield.

MICHAEL BROOKS has opened his practice of otolaryngology and maxillofacial surgery at the Medical Arts Building, 1203 Jefferson Street in Laurel.

ROBERT L. BUCKLEY, JR., announces the relocation of his office for the practice of pediatric and adolescent medicine to 2461 Fifth Street North in Columbus.

J. ERIC CHRISTMAN announces the opening of his office for the practice of ob-gyn at the Medical Plaza Building, 127 Lameuse Street in Biloxi.

ROBERT L. COBB has associated with the Gulf Coast Surgical and Diagnostic Center, P.A., for the practice of internal medicine at Medical Plaza, Vancleave Road in Ocean Springs.

TOM S. COOPER has set up his practice of ophthalmology at Suite 305, Bobo Building, Sunflower Avenue in Clarksdale.

BENJAMIN CRAWFORD, III, has associated with E. J. PRICE and LEDON LANGSTON of McComb for the practice of ob-gyn at the Medical Arts Building, 300 Rawls Drive.

MARION L. DODSON announces the opening of his office for the practice of ear, nose and throat and facial cosmetic surgery at 4500 15th Street in Gulfport.

JOHN BERLYN EDWARDS announces the relocation of his office for plastic, reconstructive and hand surgery to Medical Plaza Building, Suite 205, 127 Lameuse Street in Biloxi.

BERNARD H. ELLIS, SR., announces the opening of his office for the practice of psychiatry at 823 2nd Avenue South in Columbus.

CHARLES W. EMERSON has associated with the Mississippi Methodist Rehabilitation Center and Hospital, Inc., for the practice of orthopedic surgery and hand surgery at 1350 East Woodrow Wilson Drive in Jackson.

THOMAS C. GARROTT announces the relocation of his office for the practice of dermatology to Medical Plaza Building, Suite 203, 127 Lameuse Street in Biloxi.

DINESH GOEL and A. B. HOWARD have set up prac-

tice in Prentiss. Dr. Goel will practice surgery at Jefferson Davis County Hospital and his offices will be in the clinic formerly occupied by DAVID DALE. Dr. Howard will practice family medicine in the medical offices in South Prentiss Shopping Center.

HUGH LEE GOWAN and Mrs. Gowan of Pickens were honored with a reception at the Pickens Recreation Center to mark the occasion of Dr. Gowan's 25 years of service to Pickens.

BARRY W. HOLCOMB announces his association with The Street Clinic in Vicksburg for the practice of internal medicine.

JEFFERSON DAVIS HOUSE of Sledge has been honored by the community for his more than 50 years of service to the people of Sledge and the surrounding area.

LYNN B. MCMAHAN has associated with STONEY WILLIAMSON of Hattiesburg for the practice of ophthalmology at Hattiesburg Eye Clinic, P.A., Medical Plaza Building, Suite 106.

GEORGE K. MCMULLAN, JR., has associated with the Hinds Cardiology Clinic, P.A., for the practice of cardiology at Hinds Professional Building, 1815 Hospital Blvd. in Jackson.

JACK A. MCNEIL has associated with ROBERT E. BLEDSOE and W. VANCE BYARS, II, in The Greenville Clinic for Women, P.A., for the practice of obstetrics, gynecology and infertility at 1314 Hospital Street in Greenville.

PAUL H. MOORE of Pascagoula has been appointed to the State Board of Health's Radiation Advisory Committee.

TOXEY M. MORRIS announces the opening of his office for the practice of urological surgery at 405 South 28th Avenue, Medical Arts Building, in Hattiesburg.

JOHN P. MURRAY has associated with RALPH SNEED and TERRELL D. BLANTON in the practice of otolaryngology at The Jackson Ear, Nose and Throat Clinic, 916 North State Street in Jackson.

S. K. PUROHIT has associated with P. S. GANARAJ of Tylertown at offices on 1213 Magnolia Avenue.

JOHN E. REED, JR., and THOMAS E. SHEFFIELD have associated with FRANK J. BAIRD and A. ROBERT DILL in Internal Medicine Associates of Columbus, P.A., for the practice of internal medicine at 425 Hospital Drive, Suite 6, in Columbus.

ROBERT M. RITTER of Jackson was featured speaker at the July 18 educational program of the Mississippi Council on Epilepsy held at St. Dominic Hospital. Dr. Ritter discussed the psychological needs of patients with epilepsy.

DALE RUSSWURM has associated with HANNELORE H. GILES of Hattiesburg in the Medical Group of Hattiesburg, P.A., for the practice of internal medicine at 820 South 28th Avenue.

JOHN R. SANDERS has associated with Obstetrics and Gynecology Associates, P.A., of Tupelo for the practice of ob-gyn at 607 Brunson Drive in Tupelo.

SUSAN SIMMONS has opened her family practice of medicine at the Tom Bailey Memorial Outpatient Clinic in Maben.

ROBERT ALLEN SMITH announces his association with Jackson Plastic Surgery Clinic, P.A., for the practice of plastic and reconstructive surgery at 508 Medical Arts Building in Jackson.

EARLE T. STUBBLEFIELD has associated with The Simmons Clinic for Women, P.A., for the practice of ob-gyn at 1030 N. Flowood Drive in Jackson.

BARRY D. SUBER has associated with the Natchez Medical Clinic for the practice of internal medicine.

HANOCH TALMOR has associated with the Field Clinic in Centreville for practice limited to diseases of children.

DOUGLAS F. THOMAS has associated with the Hattiesburg Clinic Professional Association for the practice of internal medicine at 415 S. 28th Avenue.

CLIFFORD TILLMAN of Natchez has been named to the Mississippi Heart Association Board of Directors to represent District 1.

E. G. TUTOR announces the opening of his new clinic at 1202 Hospital Street in Greenville.

THURSTON E. WILKES, II, has associated with JASPER B. BECKER, JR., of Brookhaven for the practice of urology at Brookhaven Urology Clinic, Medical Arts Building, 439 North Jackson Street.

RONALD B. WILLIAMS has associated with JAMES H. SAMS of Columbus for the practice of family medicine and anesthesiology at 321 Hospital Drive.

JOHN A. WIMBERLY has associated with the Stewart Reed Clinic at 233 Courthouse Road in Gulfport for the general practice of medicine.

W. RUSSELL YOUNG has associated with JIM C. BARNETT of Brookhaven in the Family Clinic, Highway 51 N.

MBMC Opens Chemical Dependency Unit

Paul J. Pryor, Executive Director of the Mississippi Baptist Medical Center, announces the opening of a 32-bed chemical dependency unit unlike any other program available to alcoholics in Mississippi.

He said the program has been approved by the center's board of trustees and has the backing and support of the Jackson Council on Alcoholism, Alcoholics Anonymous and the Alcohol-Abuse Division of the State Mental Health Department.

"The unit," said Pryor, "will be directed by key people who, over the past five years, developed a similar unit at Nebraska Methodist Hospital in Omaha into the foremost facility of its kind in the entire United States."

He said William Crooks and Mrs. Mary Ross, director and chief counselor, respectively, of the Omaha facility, are already on the job. Miss Doris Kuhn is head nurse. Additional personnel are being added, he said.

Crooks said the Mississippi Baptist Medical Center Chemical Dependency Unit (to be located in the Gilfoy Building of the center complex) "is designed to rehabilitate the chemically dependent person to again become a responsible member of society."

He emphasized that the unit "is not just a one-day, in-and-out detoxification stop for the alcoholic. Alcoholism is a disease—a treatable disease which affects every area of one's life. We will treat all aspects—physical, psychological, social and spiritual.

"To merely detoxify the patient would not begin to touch the disease itself. Each patient at the center will be required to take, in its entirety, a two-phase course of treatment lasting about 35 days. The effectiveness of this course was proven over and over again in Omaha.

"The first phase is detoxification—withdrawal from dependency upon all mood-altering chemicals, including alcohol. The second phase is intensive inpatient treatment. The third phase calls for comprehensive after-care and follow-up over an indefinite period."

Crooks said referrals can be made not only by physicians but also by clergymen, courts, industry, business, friends, family, Alcoholics Anonymous and others. The medical staff of Mississippi Baptist Medical Center will work closely with the unit through a special committee.

Mrs. Ross described the concept of treatment as "a program of intervention. An alcoholic can be treated long before he admits he needs help. We can intervene, hopefully, long before he reaches that stage—before his condition deteriorates to the danger point."

Actuary Explains SSA Deficits

The chief actuary of the Social Security Administration, A. Haeworth Robertson, in a recent speech to the National Association of Life Companies, explained the unexpected crisis that has so suddenly been thrust upon the nation's retirement and insurance system. Four years ago the SSA did not anticipate any deficits. Since then and until this year relatively small deficits were foreseen.

It, therefore, comes as a shock to the country to learn that the Social Security Trust Funds could "be depleted by about 1982" and suffer what Mr. Robertson called "an extremely large deficit" averaging 7.9 per cent of taxable payroll for the next 75 years.

Mr. Robertson told the insurance executives "the relatively small deficit which began in 1975 and is expected to continue during each of the next 25 years is a result of these factors:

"Unprecedented and unanticipated inflation in recent years and approximately corresponding increases in benefits (benefit increases of 11 per cent in 1974, 8 per cent in 1975 and 6.4 per cent in 1976), and an expectation that inflation will continue at higher levels in the future than was formerly anticipated.

"Unexpectedly high rates of unemployment beginning in 1974, resulting in less than anticipated tax income.

"Higher than expected disability insurance expenditures in recent years and an expectation that future disability costs will be higher than formerly anticipated."

"It is possible that Social Security expenditures will eventually rise to over 20 per cent of taxable payroll" declared Mr. Robertson. At the present maximum taxable wage per job a 30 per cent SS tax would exceed $3,000.

Book Reviews

Textbook of Basic Emergency Medicine. Edited by Robert H. Miller, M.D., and James R. Cantrell, M.D. 233 pages with 184 illustrations. St. Louis: The C. V. Mosby Co., 1975. $6.95.

This book is certainly of limited use for physicians; and it should not be mistaken for a physician's textbook or reference manual. It covers basic medical physiology with clinical application, especially in the cardiovascular and pulmonary areas. Methods of CPR are adequately discussed, including a section on common mistakes made during resuscitation; and stabilization of fractures and recognition of vascular and neurologic complications are covered.

A paramedic, nurse, or E.M.T. who has read and understands this publication could be instrumental in making the correct initial clinical evaluation and reporting his findings clearly and with correct terminology to a physician. In short, this publication could be a valuable tool in training paramedical personnel to recognize true emergencies and to begin appropriate first aid.

RONNIE S. CHRISTIAN, M.D.
Jackson, MS

Genetic Screening: Programs, Principles, and Research. Report of the Committee for the Study of Inborn Errors of Metabolism. 388 pages. Washington, D. C.: Printing and Publishing Office, National Academy of Sciences, 1975. $6.00.

"Genetic screening may be defined as a search in a population for persons possessing certain genotypes that (1) are already associated with disease or predispose to disease, (2) may lead to disease in their descendants, or (3) produce other variations not known to be associated with disease."

The commission for the Study of Inborn Errors of Metabolism was given the assignment to review the many aspects of genetic screening (practical, social, legal, etc.). *Genetic Screening* reviews the commission's findings and recommendations. With the science of medical genetics exploding as it is and with all the developing implications of this science, the task of the commission was gargantuan. Indeed, one might ask whether it is possible for a committee of 17 persons to take on such a task and come out with any meaningful consensus, overview, or useful guides. The answer is yes, as a reading of the book should indicate. The book is a most thoughtful document. It is not the last word on genetic screening. But it is a strong first word, pointing out what is known, what is firm, what is not known, and what is not firm. It is a most useful document and we recommend it as such to all those interested.

This is not a textbook on medical genetics. Actually, it presupposes that the reader is familiar with genetics and has some appreciation for its existing and its potential roles in our society's health care system. However, as the committee itself finds, the role of genetics in medicine is largely unrecognized and unappreciated by many persons, including physicians. This is unfortunate since, as the committee points out, the impact of genetics on medicine is substantial. For example, in a survey of the relative frequency of causes of disease of hospitalized children in Baltimore it was found that 6.4 per cent of the causes were related to a single gene, 0.7 per cent to chromosomal problems, and 31.5 per cent were thought gene influenced—a total of well over a third of causes of disease in these children. One major reason for the relative underappreciation of medical genetics is due to an underexposure of health workers and laymen to genetics. In a survey of a sample of board certified pediatricians, obstetricians/gynecologists, and family physicians, it was found that nearly three quarters of those surveyed had no formal courses in genetics during their training. Other reasons for this underappreciation are given in the book; we will not review them here. Suffice it to say, more emphasis in genetics is needed at all levels of education (from high school to advanced medical).

The book covers many areas:

(1) There is a major section on Phenylketonuria (PKU) covering such things as historical experience and lessons learned, legislation, and recommendations. It gives much insight into the basis of many of the past and present problems, controversies, and misunderstandings related to PKU.

(2) It covers other diseases and lists the many reasons for screening. As elsewhere in this book, findings and recommendations have tapped heavily on the experiences, both good and bad, of many programs and people.

(3) It covers principles of screening from the legal, ethical, and economic perspectives.

(4) It makes an attempt to give guidelines for the development of screening programs. Again the many aspects are covered: methodology, responsibility, who to screen, what to screen, costs, etc.

State legislation related to PKU and other genetic screening is covered in this document in a couple of tables and a paragraph or two throughout the book. This was much too brief and scant (but forgivable since to cover each state in detail would have been beyond the scope of the document). Some 43 states have PKU legislation. Mississippi does not. There are other types of screening laws in existence such as laws involving sickle cell anemia (Mississippi has such a law). Some state laws are poorly written and thus ineffective (or may even be damaging) since all ramifications and needs had not been carefully considered. The current feeling seems to be one of caution in passing new laws. For example many argue that it is senseless to pass a new law for each disease. Perhaps something better and flexible enough to keep up with the advancing technology can be done. Many believe that the state of Maryland came up with a good—perhaps model—screening law. Maryland's law sets up a Commission on Hereditary Disorders which is flexible and has a broad base of input. The principles and cautions seen in Maryland's law are similar to those seen throughout *Genetic Screening.* What Mississippi should do (or should not do) about legislation has yet to be agreed upon (but many are thinking on it). Laws aside, genetics is not being ignored in Mississippi. Many (but not all) of our children are screened for PKU. Presently, some (but not all) "high risk" children are being screened for other genetic diseases. If Mississippi decides to go beyond this, it can learn a lot from *Genetic Screening: Programs, Principles, and Practices.*

Fred J. Oelshlegel, Jr., Ph.D.
Donna C. Sullivan, B.S.
Mississippi Inherited Metabolic
Disorders Program
Department of Preventive Medicine
Division of Medical Genetics
University of Mississippi Medical Center
Jackson, MS

Dr. Sherline Receives UMC Ob-Gyn Award

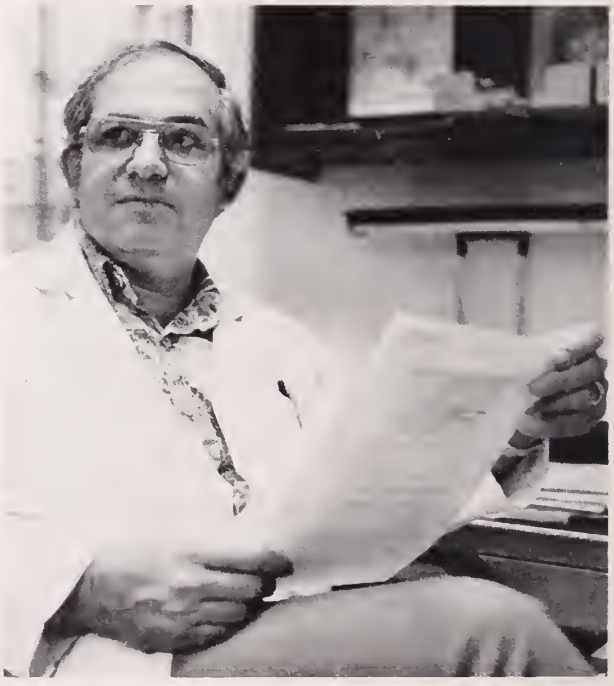
Dr. Donald M. Sherline, professor of obstetrics-gynecology and director of the maternal-fetal medicine division at the University of Mississippi Medical Center, is recipient of the UMC ob-gyn department's Shirley A. Faulkner Award for 1975-1976.

The award goes annually to the individual who "makes the most significant contribution toward improving the care of obstetrical patients in Mississippi."

Dr. Sherline, who joined the UMC faculty in 1969 and has served as associate chairman and acting chairman of the ob-gyn department, chairs the State Board of Health Perinatal Advisory Council.

Former UMC Department of Obstetrics-Gynecology chairman Dr. Henry A. Thiede and Mrs. Thiede established the Faulkner Award in memory of Miss Faulkner, a nurse-midwife on the UMC faculty from 1969 until her death in 1972.

Previous recipients are Dr. Peter Boelens, a pediatrician, and Ms. Marie Meglen and Ms. Connie Juzwiak, both nurse-midwives.



Dr. Donald M. Sherline, professor of obstetrics-gynecology at the University of Mississippi Medical Center, has been named recipient of the UMC Shirley A. Faulkner Award for 1975-1976. The award goes annually to the individual who has made major contributions to improved health care for expectant mothers in Mississippi.

MSMA Trustees Conduct Summer Meeting

The association's Board of Trustees conducted its regular summer meeting on August 19-20. The Board considered a wide range of subjects to include reports on implementation of Public Law 93-641, the status of the association's chiropractic litigation, the status of the Mississippi Medical Fraternal and Educational Society and a report from the association's delegates to the AMA June meeting.

Dr. Howard Clark, president of Mississippi Health Systems Agency, Inc., met with the board to discuss the present status and future plans for implementing Public Law 93-641 in Mississippi. Dr. Clark reported that MHSA will give top priority to developing a plan to divide Mississippi into three or more Health Service Areas so as to give all regions of the state a stronger voice in health planning activities conducted under Public Law 93-641. There would be a health systems agency for each area.

The Board reviewed the status of implementation of a program for Mississippi physicians to receive professional liability protection and education as authorized by the House of Delegates at the October 1975 Special Session and reported to the House at the recent 108th Annual Session. The Mississippi Medical Fraternal and Educational Society has been incorporated for this purpose. Tax exempt status for the MMFES is presently being sought prior to further steps being taken to organize the society.

The status of the association's litigation against chiropractors was reviewed. The suit which seeks to prohibit the use of certain treatment modalities by chiropractors will resume in Jackson in September. The Board expressed a strong desire to pursue this litigation to the fullest and a letter will be sent to the membership in this regard.

MSMA's delegates to the AMA June Meeting reported on actions of the AMA House of Delegates to include approval of an MSMA resolution urging the AMA to study the feasibility of establishing a patient compensation program for malpractice similar to the present Workmen's Compensation Program. AMA action on another MSMA resolution seeking equity in Medicare payments between various areas of the country consisted of recommendations that the AMA (1) continue to emphasize UCR as the basis for physician payment, (2) urge physicians to bill their usual fee even if payors reduce the amount of payment and (3) seek repeal of the Medicare "economic index."

In other actions, the Board considered a request for the association to intervene in the orthopaedic residency matter at the UMC. The Board expressed its deep concern about the orthopaedic residency matter and its desire to see a good orthopaedic program at the UMC. The Board reiterated its offer to assist the UMC in the matter based on a request from the Vice Chancellor for such assistance. The Board further acted to establish a malpractice screening panel before which physicians could voluntarily appear to have the medical merits of a malpractice allegation determined. Additionally, the Board approved a schedule and budget for the 109th Annual Session as proposed by the Council on Scientific Assembly; reviewed the association's recent bid to continue to contract as data processor for the Mississippi Foundation for Medical Care PSRO activity; and directed the staff to submit a bid for continuation of the association's contract as fiscal administrator for professional services under CHAMPUS in Mississippi. The Board also received the resignations of Drs. John R. Lovelace and Joe S. Covington as nominees to the Governor for Public Health Districts 2 and 5 on the Mississippi State Board of Health. The Board will act to fill these vacancies later.

MAFP Elects Officers and Holds Annual Meeting

Dr. Walter H. Rose of Indianola is the new president of the Mississippi Academy of Family Physicians. Dr. Rose was inaugurated during the academy's annual scientific assembly held July 7-10 in Biloxi.

Officers were elected during the business session on Thursday, July 8, and installed at the banquet on Friday evening by Dr. Carl B. Hall of Charleston, WV, president of the American Academy of Family Physicians. New officers are: president-elect—Dr. Ralph Brock of McComb; vice president—Dr. John M. Estess of Hollandale; and secretary-treasurer—Dr. Edgar Johnson of Hattiesburg.

Newly elected directors for 1976-77 are: Dr. James C. Waites of Laurel, district II; Dr. Hardy B. Woodbridge, Jr. of Jackson, district IV; Dr. James W. Allison of Vicksburg, district VI; Dr. John E. Powell of Houlka, district VIII; Dr. Malcolm Moore of Tupelo, district X.

Other directors serving the term 1975-77 are: Dr. William R. Campbell of Columbia, district I; Dr. A. Keith Lay of Bay Springs, district V; Dr. J. Edward Hill of Hollandale, district VII; Dr. Thomas S. Glasgow of Grenada, district IX. Dr. Elmo Gabbert of Meadville represents district III.



Dr. Richard T. Furr (at left) of Ocean Springs, MAFP outgoing president, congratulates the newly installed president, Dr. Walter Rose of Indianola.

Elected delegates to AAFP were Drs. Joseph Johnson of Mt. Olive and Dr. James O. Stephens of Magee.



Directors elected at the 1976 session are from left, Dr. James Waites of Laurel, Dr. John E. Powell of Houlka, Dr. Malcolm Moore of Tupelo, and Dr. Hardy Woodbridge of Jackson. Not pictured is Dr. James Allison of Vicksburg.

The scientific program which had been approved for 12 hours of prescribed credit by AAFP included presentations on coronary by-pass surgery, hypertension, breast cancer, gynecology, sciatica, immunizations, diverticular disease of the colon, diagnosis and treatment of GI bleeding, chronic lung disease, and management of asthma, infectious diseases, therapy of malignant neoplasia, treatment of infertility, drug withdrawal syndromes and thyroid function testing. Additional prescribed hours were received by the preceptor workshop, orthopedic demonstrations, and teaching machines.



Dr. Charles R. Jenkins of Laurel, at left, discusses academy business with Bill Myers of Kansas City, who is in charge of AAFP membership services, and Dr. Carl B. Hall of Charleston, WV (pictured at right), president of the AAFP.

Annual Coast Athletic Injuries Seminar Held

The annual Gulf Coast Athletic Injury Seminar was held on July 27 at Memorial Hospital in Gulfport. The session was open to all interested coaches and physicians and was moderated by Dr. A. C. Hewes of Gulfport.

The program, under the auspices of the American College of Surgeons, included: "Air way management" by Dr. Al Terry; "Nutrition" by Dr. Mitchell; "Young bone structure" by Dr. Magruder Corban of Gulfport; "Fluids" by Coach Wells of Tulane University; "Prevention and rehabilitation of football injuries" by Bubba Porche, athletic trainer at Tulane; and "Team physicals" by Lindy Callahan, athletic director of Gulfport Public Schools.

MHSA Receives Conditional Approval

The Department of H.E.W. has given Mississippi Health Systems Agency, Inc. "conditional" approval for one year as Mississippi's Health System Agency under requirements of Public Law 93-641 (The National Health Planning and Resources Development Act of 1974). MHSA's application had been protested by MSMA which cited organizational deficiencies and urged H.E.W. to seek division of the state into more than one health service area.

In its approval H.E.W. cited a "high priority" for MHSA to submit a plan within the year for redesignating the state into multiple health service areas. Under federal criteria Mississippi could have up to four health service areas with a health system agency for each area.

H.E.W. also said MHSA must consult medical societies about physicians on its board and amend its by-laws to add other health professional groups. In its protest MSMA pointed out that MHSA had permanently slotted health positions for chiropractors and optometrists completely ignoring other health groups who numerically outnumber both groups in the state.

H.E.W. also told MHSA to reconsider its organization of sub-area councils to make sure geographic representation is proportionate. MHSA must further produce proof that state law allows the governor to appoint the MHSA president. In its protest MSMA had cited state law against such appointment and the president of MHSA subsequently resigned.

MHSA has not received notice of how much money H.E.W. will provide to run the agency for one year. The amount is expected to be less than the $500,000 requested by MHSA.

Mississippi Has First Statewide HBP Program

The Mississippi State Health Department initiated, approximately 18 months ago, a statewide high blood pressure program which, at present, is the only statewide *treatment* program in existence.

Implemented through all 82 county health departments in the state, the program includes essential services recommended by the National High Blood Pressure Education Program for effective community level participation in HBP control. These include: (1) detection with strong referral and follow-up to medical diagnosis; (2) diagnosis and treatment of those without a physician and/or without the ability to pay for care and medication; (3) substantial effort to reach rural populations; (4) patient tracking and follow-up system to facilitate patient management; (5) data collection and analysis for program evaluation; (6) training of nurses in HBP control; (7) private physician involvement through joint management of HBP patients; (8) utilization of public health facilities and staff in HBP control.

By October of 1975, nine months after its inception, the Mississippi program had screened over 50,000 people in 78 of the state's 82 counties, and had approximately 3,500 people on drug therapy provided by the program. By May of this year, over 130,000 had been screened and 8,000 were receiving treatment through the state program.

The information on each patient, as it is added to the registry, is always transferred to the patient's physician for active integration into the management of that person.

Continuing education is an important part of the Mississippi program. A series of nursing education workshops have been conducted as part of the program for more than 400 public health and hospital nurses.

There is increasing cooperation between the state health department program and other detection programs carried on in the state, such as those conducted by the Mississippi Heart Association and the Mississippi Department of Public Welfare.

For further information write: Lawrence J. Clark, Jr., M.D., Mississippi State Board of Health, 2423 North State Street, P.O. Box 1700, Jackson, MS 39205.

UMC Offers Substance Abuse Clinics

Substance abuse clinics at the University of Mississippi Medical Center are open to persons who may have trouble controlling their drinking, smoking, or eating.

Under the direction of Dr. William G. Johnson, associate professor of psychiatry (psychology), the clinics are based on the concept that people who abuse cigarettes, alcohol, or food are no more likely to have psychological disturbances than those who do not.

The emphasis, said Dr. Johnson, is on solving the day-to-day problems associated with the excess.

Exercise is encouraged in all the clinics, both as a means of balancing caloric intake with energy expended and as a substitute behavior for indulgent habits.

Although clinic participants meet in group sessions, each person's problem is treated on an individual basis.

"Each participant learns the situations which precipitate an abusive episode by keeping a diary listing the time and place they eat, drink, or smoke," Dr. Johnson said. "We try to help them avoid those situations."

Those who enroll in the program are screened and assigned to a compatible group which meets weekly. There is a clinic fee.

Medical Center Has New Faculty Members

Five new faculty members took on teaching responsibilities at the University of Mississippi School of Medicine this summer.

Dr. Norman C. Nelson, vice chancellor for health affairs, announced their appointments on approval of the Board of Trustees of Institutions of Higher Learning.

School of Medicine appointees are Dr. Alan Eugene Stallings, assistant professor of anesthesiology, and Dr. Robert Edwin Lewis, instructor in anesthesiology who also holds the rank of instructor in the UMC Department of Pathology.

Appointed to Medical Center departments are Dr. Thomas Edward Lohmeier, assistant professor of physiology-biophysics; Dr. Thomas Edwin Jackson, instructor in physiology-biophysics; and Dr. Norman Francis Capra, instructor in anatomy. Faculty in the center-wide departments teach both medical and dental students.

Dr. Stallings came to the Mississippi health sciences center in 1974 as an anesthesiology resident. He had interned and taken one year's residency training at the University of Arkansas Medical Center, where he earned the M.D. degree in 1972. He also holds a B.A. degree from Hendrix College.

Dr. Lohmeier completed a fellowship at UMC before taking his present post. Formerly a fellow at the University of Missouri School of Medicine, he earned Ph.D., M.S., and B.A. degrees at the University of California at Davis.

Both Dr. Jackson and Dr. Lewis completed requirements for Ph.D. degrees at the Mississippi Medical Center this summer. Dr. Jackson took undergraduate work at the University of Cincinnati and got his master's at Mississippi State University. Dr. Lewis holds M.S. and B.A. degrees from the University of Mississippi.

Dr. Capra got his Ph.D. degree at the University of Alabama in Birmingham in July. He also earned his M.S. degree there and has a B.S. degree from Birmingham Southern College.

MBMC Sponsors Second Cardiovascular Seminar

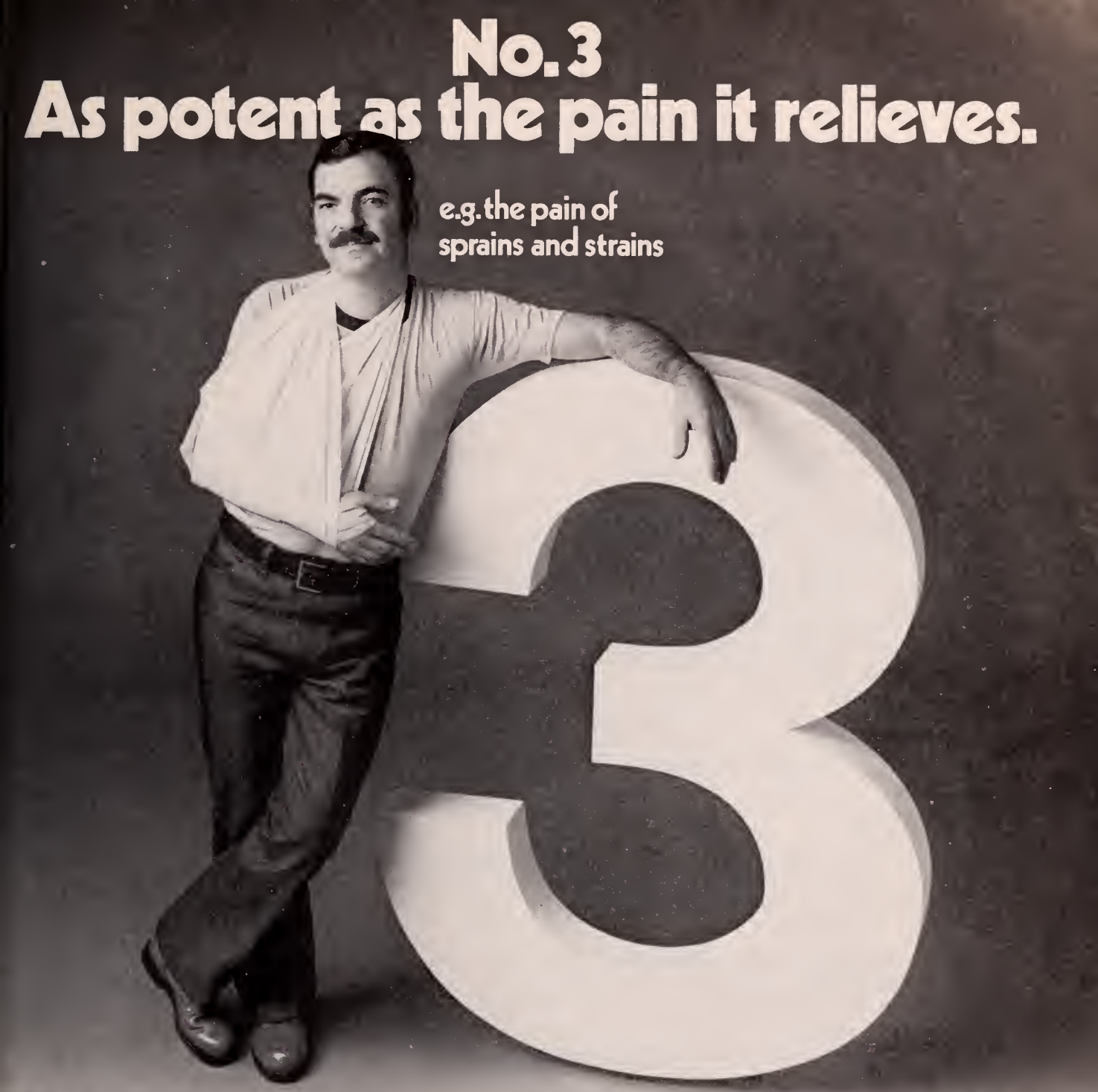
The second annual cardiovascular seminar, sponsored by the Cardiovascular Division and the Medical Education Committee of the Mississippi Baptist Hospital, will be held Sept. 24-25, 1976, at the Downtown Holiday Inn in Jackson.

Registration fee is $35.00 and registration will be free for medical students, interns and residents. The seminar is approved for Category 1 credit, AMA Physicians Recognition Award.

Visiting faculty will be Dr. Denton Cooley, Texas Heart Institute, Houston; Dr. Fred Allison, chairman, department of medicine, LSU School of Medicine, New Orleans; and Dr. Barry Rutherford, director, coronary care units, Mayo Clinics, Rochester, MN.

Mississippi Baptist Medical Center staff who will be on the program are Drs. H. Davis Dear, Thomas L. Kilgore, Martin McMullan, McKamy Smith, and Morris E. Williams.

No. 3
As potent as the pain it relieves.



NOT TOO LITTLE
- as potent as the pain you need to relieve in patients with fractures, sprains, strains, wounds, contusions, and the pain of surgical convalescence
- unlike acetaminophen/codeine combinations, it does not sacrifice anti-inflammatory action

NOT TOO MUCH
- potent—yet not excessive
- addiction liability low

NOT TOO EXPENSIVE
- brand-name quality, yet reasonable in cost
- readily available in both hospital and local pharmacies

CONVENIENCE
- telephone Rx in most states, up to 5 refills in 6 months at your discretion (where state law permits)

EMPIRIN® COMPOUND WITH CODEINE NO. 3

codeine phosphate* (32.4 mg) gr ½
Each tablet also contains: aspirin gr 3½, phenacetin gr 2½, caffeine gr ½. *Warning—may be habit-forming

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Pulmonary Medicine Course Planned

The changing scene in pulmonary medicine along with major unsolved challenges demand a frequent update of the "state of the art" in identifying and managing clinical problems. A postgraduate course, "Pulmonary Medicine—1976," sponsored by the American College of Chest Physicians and the University of Colorado Medical Center will present physicians with an opportunity to exchange ideas of diagnosis and treatment of pulmonary diseases. The course will be held in Keystone, CO, Sept. 15-17.

Major topics to be discussed are lung cancer, interstitial lung disease, asthma, pulmonary embolism and chronic obstructive pulmonary disease. Lectures and problem solving group sessions will be held.

This course has a credit of 16 hours toward the American Medical Association's Physician Recognition Award under Category 1. Tuition fees for the Keystone course are: ACCP members, $155.00; non-member physicians, $180.00; residents, allied health, $100.00. The tuition fee includes a ticket to a rodeo and barbeque scheduled for Thursday.

For further information, contact: Dale E. Braddy, M.S., Director of Continuing Education, American College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068.

UMC Announces Faculty Promotions

Higher academic rank went to 23 School of Medicine faculty members at the University of Mississippi Medical Center this summer. Seven on the teaching staff rose to full professor.

Vice Chancellor for Health Affairs Dr. Norman C. Nelson announced the promotions following Board of Trustees, Institutions of Higher Learning, approval.

Newly promoted to professor of medicine are Dr. John D. Bower, Dr. Armin F. Haerer, and Dr. Francis S. Morrison. Dr. Joseph C. Gabel is professor of anesthesiology, and Dr. A. Wallace Hayes moved up to professor of pharmacology.

Dr. Raul E. Valenzuela is new professor of surgery (ophthalmology), and Dr. Stanley Weitzner is a professor of pathology.

Medical school faculty promoted to associate professor are Dr. Delmar R. Caldwell, surgery (ophthalmology); Dr. D. David Glass, anesthesiology; Dr. Richard C. Hutchison, medicine; Dr. Patricia C. Moynihan, surgery; Dr. Seshadri Raju, surgery; and Dr. James G. Williams, psychiatry (part-time).

Moving up to assistant professor are Dr. Lloyd B. Gallimore, Jr., and Dr. John H. Romfh, anatomy; Dr. Robert Earl Drake, anesthesiology; Dr. Angel D. Markov, Dr. M. A. Greganti, and Dr. Allison Randle White (part-time), medicine; Dr. Gunnbjorg A. Lindseth, pathology; Dr. Richard D. Olsen, pediatrics; Dr. David Foy, psychiatry (part-time); and Dr. Philip Cranston, radiology.

New Class Enrolls in School of Medicine

The University of Mississippi School of Medicine Class of 1980 registers this month at the Medical Center, with 150 again expected to enter.

This is the third consecutive year the new class has numbered 150, according to UMC Vice Chancellor Dr. Norman C. Nelson.

Increased appropriations from the 1974 state legislature made the enrollment upsurge possible by funding expansion of the basic sciences faculty.

The 1976 legislature again increased the school appropriation to allow expansion of clinical faculty as the initial class of 150 reaches the junior year.

Total anticipated enrollment in the UMC medical school this fall is 563, compared to 368 just five years ago.

SBH Discloses Swine Flu Vaccination Plans

State Board of Health officials are hoping to begin the mass influenza immunization program before Oct. 1 since the liability coverage issue has been solved by Congress' recent passage of a bill to insure the swine flu vaccine program against injury suits.

According to Dr. Durward Blakey, chief, Bureau of Disease Control, state health department officials began planning for the mass immunization program weeks ago.

"Now that everything is go for the program, we hope that it will only be a matter of a few weeks before we begin receiving the first doses of the vaccine," said Dr. Blakey.

The immunization program will offer free shots to every citizen. The vaccine protects against the flu virus similar to the one in 1918 that killed 20 million people across the world.

According to Dr. Blakey, a virus of this type was identified in New Jersey this past spring, its first appearance in 60 years. Public health experts predicted a recurrence as early as the late 1970's or early 1980's.

Dr. Blakey indicated that the virus attacks 35 out of 100 people and has as high an attack rate as flu ever goes. He said the fatality rate is highest in the 20 to 40 age group.

Blakey indicated that the State Board of Health plans to vaccinate high-risk persons, the elderly and chronically ill, first. They will get protection against swine flu and another strain, A/Victoria, also expected to be a problem this winter.

He indicated that the vaccine is safe for children, but questions have been raised about the size dose to be used. Field trials are currently being conducted to solve this question.

Dr. Blakey said that the "killed" vaccine should protect at least 70 to 90 per cent of the people who get them.

PRINTING — OFFICE SUPPLIES

EQUIPMENT — FURNITURE



Premier Printing Company

2485 West Capitol Jackson, Mississippi

Phone 352-4091

CLASSIFIED

ATTALA COUNTY Nursing Center wishes to retain the services of a physician to serve as Medical Director of this long term care center. For information contact Jim Brewer, Administrator, 289-1200.

Index to Advertisers

Attala County Nursing Center 19

Blue Cross and Blue Shield of MS 18
Burroughs Wellcome Co. 289

Canton Exchange Bank 6
Coca-Cola 11
Compass Industries, Inc. 16

Family Practice Physicians 14

Hill Crest Hospital 8
Hyrex-Key Pharmaceuticals 10

Key Pharmaceuticals, Inc. 7

Eli Lilly and Co. front cover

Mallinckrodt, Inc. 10B, 10C
Mead Johnson Laboratories 12
MS Stationery Co. 17

Pennwalt Prescription Products 276B, 276C, 276D
Pharmaceutical Manufacturers Assoc. 14D, 15
Premier Printing Co. 19

Roche Laboratories
second cover, 3, 268B, 268C, 268D, third and fourth covers
Roerig and Co. 14B, 14C

Smith Kline and French 14A

The Upjohn Co. 268A

Thomas Yates and Co. 4

IN CONCLUSION

A study recently completed by the Social Science Research Center at Mississippi State University has provided valuable new data on teenage drinking and driving in Mississippi. Funded by the DAAA from formula grant funds, research included the development and testing of an alcohol curriculum in driver education classes, an analysis of drinking and driving patterns of high school students, and a survey of drinking patterns of driver education instructors. Schools in Bogue Chitto, Clarksdale, Grenada, Gulfport, New Albany and West Point were studied.

Increasing expensive malpractice insurance is forcing many hospitals to pass along the cost of this protection to patients by raising rates substantially, a recent nationwide survey indicates. Average increase for all hospitals in 1974-75 was 198 per cent. Sixty-one per cent of responding hospitals say they already have raised rates to absorb the climbing costs of malpractice insurance and another four per cent say they probably will raise rates soon. Random spot check survey was conducted by Malpractice Lifeline, an independent newsletter.

Driving long hours without a break, alcohol consumption, a monotonous straight roadway -- all have been blamed for drowsiness behind the wheel. Now a Duke University psychologist reports a formal education also may help put a driver to sleep. William Erwin, in a National Driving Center poll, found 3.2 per cent of drivers with only a grade-school education said they became drowsy while driving, but 84.9 per cent of those with postgraduate degrees reported feeling sleepy. He speculates that routine task of driving may be more boring to highly-educated.

Physicians helping physicians is the concept behind a program to treat the alcoholism problems in Georgia's medical community. Known as the Disabled Doctors Plan, the program is financed and supported by the Medical Association of Georgia and implemented through a 13-member Physicians' Consultant Committee composed largely of recovered addicted physicians. The committee acts as advocate for the disabled doctor, dealing with the total recovery program including education, identification, rehabilitation and reentry.

A National Preventive Dentistry Demonstration Program -- designed to involve up to 20,000 elementary school children -- was announced at a recent meeting of national dental organizations. The 5½ year program will be conducted by the American Fund for Dental Health and supported by the Robert Wood Johnson Foundation. Procedures, such as application of fluorides and sealants, plaque control and health education, will be evaluated to determine their cost and the relative degrees of protection afforded against tooth decay and gum disease.

THE ANXIETY-SPECIFIC.

- a predictable pattern of patient response
- seldom associated with serious side effects, in proper dosage
- rarely interferes with mental acuity
- used concomitantly with many primary medications
- three dosage strengths meet most patient needs

LIBRIUM® Ⓘⓥ

chlordiazepoxide HCl/Roche

5mg, 10mg, 25mg capsules

Libritabs® (chlordiazepoxide) available in 5 mg, 10 mg and 25 mg tablets.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido —all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.;* severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see following page.

THE ANXIETY-SPECIFI

Since its discovery in the research laboratories at Roche, Libr
has been the object of ongoing pharmacologic and clinical investigati

The published record on Librium is enormous. So large, in fac
put it into a computer literature retrieval system to make it more accessible
in answering your inquiries.*

It's a record that reveals a consistent pattern of patient response.
A highly favorable benefits-to-risk ratio. And minimal interference with
many primary medications.

Doing one thing well. Basically, that's what Librium is all about.

LIBRIUM® (IV)
chlordiazepoxide HCl/Roche



LIBRARY
SEP 17 1976
NEW YORK ACADEMY OF MEDICINE

ROCHE

*If you have a question about Librium or any other Roche product, write to Professional Services, Roche Laboratories, Nutley, New Jersey 07110.

Please see preceding page for a summary of product information.

N.Y. ACADEMY OF MED
2 EAST 103RD ST
NEW YORK N.Y.
10029

BALCONY

JOURNAL OF THE Mississippi STATE MEDICAL ASSOCIATION

AMERICAN REVOLUTION BICENTENNIAL 1776-1976

OCTOBER 1976

From Lilly/Dista Research

NALFON®

fenoprofen calcium

300-mg.* Pulvules®

DISTA

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

Additional information available to the profession on request.

*Present as 345.9 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. fenoprofen.

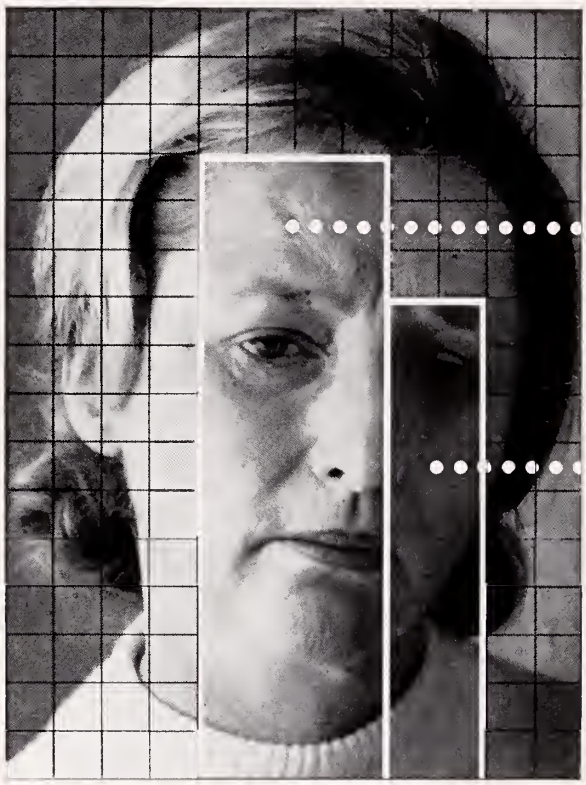
600120

This Month . . . Special Issue— Papers from American College of Physicians MS-LA Regional Meeting

AMERICAN COLLEGE OF PHYSICIANS INC 1915

M.S.M.A

Both often



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

AAP Meeting Is Set for Chicago

Medical liability, health manpower, recertification, and the problems of adolescents will be among the featured topics when the American Academy of Pediatrics holds its 45th Annual Meeting, Oct. 16-21, at the Palmer House Hotel in Chicago.

Child health professionals from throughout the hemisphere will also hear presentations on behavior modification, parent-child interaction, growth disorders, language-learning disabilities, sexuality, nutrition, neonatology, and school reading problems.

Scientific sessions scheduled for the meeting will take place under a variety of formats. General sessions, open to all registrants, will begin Monday morning, and continue throughout the day on Wednesday, as well as Thursday morning. In addition, a number of academy sections dealing with such topics as surgery, urology, cardiology, and child development will hold open meetings planned for the general membership.

Emergency Room Staffs Plan Convention

"New Perspectives . . . New Programs . . . New Orleans!" is the theme of the fourth annual combined scientific assembly sponsored by the American College of Emergency Physicians and the Emergency Department Nurses Association, which will be held Oct. 12-14 in the New Orleans Superdome.

More than 150 educational programs will be offered, reflecting the assembly's emphasis on postgraduate education. The almost 50 per cent increase in the number of programs over last year indicates the continuing effort by ACEP and EDNA to provide continuing education programs that will help maintain high standards of emergency care.

The programs offered include scientific presentations, postgraduate courses mini-lectures, technique sessions, roundtable consultations, films, workshops and panel discussions.

For more information contact ACEP, 3900 Capital City Blvd., Lansing, MI 48906.

Is there a tablet containing *only* an expectorant and *only* Glyceryl Guaiacolate? YES!

1. Patient acceptable tablet dose.
2. Single entity expectorant.
3. Measured tablet dose.
4. Sugar-free tablet.

An identifiable white, scored tablet which significantly stimulates the secretion of respiratory tract fluid.

HYTUSS TABS

(GLYCERYL GUAIACOLATE 100mg.)





Composition: Each sugar-free compressed tablet contains glyceryl guaiacolate 100mg. **Action and Use:** This preparation utilizes the effective expectorant action of glyceryl guaiacolate which significantly stimulates the secretion of respiratory tract fluid. The increased flow of less viscid fluid favors expectoration and has a demulcent effect on the tracheobronchial mucosa. The primary usefulness of Hytuss Tabs is to promote the change from a dry, unproductive cough to a productive cough. Hytuss is therefore useful in treating coughs due to the common cold, bronchitis, laryngitis, tracheitis, pharyngitis, influenza and the measles. The expectorant action of Hytuss may also provide symptomatic relief in some chronic respiratory disorders when the patient experiences spasms of dry nonproductive coughing. **Precautions:** Extremely large amounts may cause nausea and vomiting. **Administration and Dosage:** *Adults*—1 tablet four times daily. *Children*—6 to 12 years of age; ½ tablet 3 or 4 times daily. HOW SUPPLIED: White, scored, sugar-free, tablet in bottles of 100 - 1,000 - 5,000. **Product Identification Mark:** Hy. **Literature Available:** On request.

Available through all drug wholesalers.

Hyrex

HYREX COMPANY

832 South Cooper
Memphis, Tenn. 38104

Volume XVII
Number 10
October 1976



JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

• EDITOR
W. Moncure Dabney, M.D.
• ASSOCIATE EDITORS
George H. Martin, M.D.
Myron W. Lockey, M.D.
• MANAGING EDITOR
Nola Gibson
• PUBLICATIONS COMMITTEE
Lawrence W. Long, M.D.
Chairman
Robert R. McGee, M.D.
T. A. Baines, M.D.
and the editors
• THE ASSOCIATION
Lyne S. Gamble, M.D.
President
James O. Gilmore, M.D.
President-Elect
J. Elmer Nix, M.D.
Secretary-Treasurer
C. D. Taylor, Jr., M.D.
Speaker
R. Faser Triplett, M.D.
Vice Speaker
Charles L. Mathews
Executive Secretary
H. Cody Harrell
Assistant Executive Secretary
William F. Roberts
Legal Counsel

The Journal of the Mississippi State Medical Association is owned and published monthly by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, $15.00 per annum; $2 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

CONTENTS

SCIENTIFIC PAPERS

What the Internist Should Know About Echocardiography **291** Stephen P. Glasser, M.D. Shreveport, LA

Intermittent Positive Pressure Breathing: Good Medicine or Gadgetry? **295** W. Brooks Emory, M.D. New Orleans, LA

SPECIAL ARTICLES

You Could Have Been a Steam Doctor **298** Leslie Caine Campbell Auburn, AL

Radiological Seminar CLXIII: A Simple Technique for Performing Bronchography **303** Paul H. Moore, M.D. Pascagoula, MS

Report of a Case of Clear-Cell Carcinoma of the Vagina **306** Walter H. Simmons, M.D. Jackson, MS

EDITORIALS

Radiation Dangers of Mammography **309** George H. Martin, M.D. Vicksburg, MS

Public Law 93-641 **309** Charles L. Mathews Jackson, MS

THIS MONTH

The President Speaking **308** Status of Implementation of P.L. 93-641

Medical Organization **315** 'Hands Only' May Be Decided in Court Case

Copyright 1976, Mississippi State Medical Association

helping you change things for the better

Canton Exchange Bank

A FULL SERVICE BANK

"Your Account Handled in Strict Confidence"

Each depositor insured to $40,000

Branch Offices
Canton East Branch
Bank Of Madison
Bank Of Ridgeland

FDIC

"Our 96th Year Of Continuous Service"

Federal Deposit Insurance Corporation

Cell Differentiation Course Scheduled

"Cell Differentiation and Neoplasia" will be the topic of the 30th annual Symposium on Fundamental Cancer Research to be held in Houston at the Shamrock Hilton Hotel, Mar. 2-4, 1977. Subjects to be covered include germ cell differentiation, tissue differentiation and oncogenesis, immunogenesis and neoplasia, hematopoetic stem cells, molecular mechanisms of gene expression; gene expression in early development and cancer, and stability of differentiation. Course chairman is Dr. Grady F. Saunders.

For additional information write Stephen C. Stuyck, M. D. Anderson Hospital and Tumor Institute, Houston, TX 77030.

it's the real thing

Enjoy Coca-Cola Trade-mark ®

70-37

Mississippi Council of Coca-Cola Bottlers

Medicaid Fraud Study Reported

A recent investigation of the Medicaid program concludes that there is a higher incidence of fraud and abuse than previously estimated and an equivalent degree of error and maladministration by government agencies. At least $1 billion a year is being paid out unnecessarily to entrepreneurs who provide no services, investigators conclude.

Hearings before the Senate Special Committee on Aging Aug. 30-31 detailed the experience of six committee staff members and Chairman Frank Moss (D-California) when posing as Medicaid patients in so-called Medicaid mills. The small, for-profit welfare clinics visited were in New York, California, Michigan, New Jersey and Illinois. The five states account for more than 55 per cent of the nation's $15 billion annual Medicaid expenditures.

Val J. Halamandaris, associate counsel to the committee, concluded that comparatively few physicians (and other practitioners), are paid most of the money from the Medicaid programs. "Because of complicated leasing arrangements, these doctors (mostly foreign trained practitioners) work essentially on commission and are allowed to keep only about 30 per cent of the income they generate for Medicaid mill owners, generally businessmen and not medical practitioners."

Cold/Allergy and Cough Country



Rynatan® Country

RYNATAN, for symptomatic relief of colds and allergic rhinitis. Convenient b.i.d. tablet and liquid dosage.

Rynatuss® Country

RYNATUSS, for symptomatic relief of coughs due to colds and in acute and chronic bronchitis. Convenient b.i.d. tablet and liquid dosage.

Mallinckrodt® Pharmaceuticals *Linking chemistry to medicine®*

Mallinckrodt, Inc. St. Louis, Mo. 63147

RYNATAN®: Each tablet contains Phenylephrine Tannate, 25 mg.; Chlorpheniramine Tannate, 8 mg.; Pyrilamine Tannate, 25 mg.

Each 5 ml. (1 teaspoonful) RYNATAN® PEDIATRIC SUSPENSION contains Phenylephrine Tannate, 5 mg., Chlorpheniramine Tannate, 2 mg.; Pyrilamine Tannate, 12.5 mg. CONVENIENT B.I.D. DOSAGE for convenience and economy.

INDICATIONS: RYNATAN provides symptomatic relief of the coryza and nasal congestion associated with the common cold. other upper respiratory infections and allergic rhinitis. In sinusitis, drainage from the affected sinuses may be improved.

CONTRAINDICATIONS: RYNATAN is contraindicated in those patients who are sensitive to sympathomimetic drugs.

PRECAUTIONS: Use with caution in patients with hypertension, hyperthyroidism, diabetes or coronary artery disease; warn of possible drowsiness in patients who may operate vehicles or machinery.

ADVERSE REACTIONS: Drowsiness and dryness of the mouth are occasionally associated with antihistamine therapy in some individuals.

DOSAGE AND ADMINISTRATION: RYNATAN TABLETS: 1 or 2 tablets every 12 hours.

RYNATAN PEDIATRIC SUSPENSION: For children over six years of age, 5 to 10 ml. (1 to 2 teaspoonfuls) every 12 hours; for children two to six years of age, 2.5 to 5 ml. (½ to 1 teaspoonful) every 12 hours; for children under two years of age, 1.7 ml. (⅓ teaspoonful) every 12 hours.

CAUTION: Federal (U.S.A.) law prohibits dispensing without prescription.

RYNATUSS®: Each tablet contains Carbetapentane Tannate, 60 mg.; Chlorpheniramine Tannate, 5 mg.; Ephedrine Tannate, 10 mg.; Phenylephrine Tannate, 10 mg.

Each 5 ml. (1 teaspoonful) RYNATUSS® PEDIATRIC SUSPENSION contains Carbetapentane Tannate, 30 mg. Chlorpheniramine Tannate, 4 mg. Ephedrine Tannate, 5 mg., Phenylephrine Tannate, 5 mg. CONVENIENT B.I.D. DOSAGE for convenience and economy.

INDICATIONS: In the treatment of coughs due to the common cold, asthma, and in acute and chronic bronchitis.

CONTRAINDICATIONS: RYNATUSS is contraindicated in those patients who are sensitive to sympathomimetic drugs.

PRECAUTIONS: Use with caution in patients with hypertension, hyperthyroidism, diabetes or coronary artery disease. warn of possible drowsiness in patients who may operate vehicles or machinery.

ADVERSE REACTIONS: Drowsiness and dryness of the mouth are occasionally associated with antihistamine therapy in some individuals.

DOSAGE AND ADMINISTRATION: RYNATUSS TABLETS: Adults—1 to 2 tablets every 12 hours.

RYNATUSS PEDIATRIC SUSPENSION: For children over six years of age, 5 to 10 ml. (1 to 2 teaspoonfuls) every 12 hours; for children two to six years of age, 2.5 to 5 ml. (½ to 1 teaspoonful) every 12 hours; for children under two years of age, 1.7 ml. (⅓ teaspoonful) every 12 hours.

CAUTION: Federal (U.S.A.) law prohibits dispensing without prescription.

The above represents a brief summary. See package inserts for full prescribing information.

Counsel to Authors

THE JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, Miss. 39216, in original and at least one duplicate copy. They must be typewritten double spaced on 8½ by 11-inch white bond paper with a standard typewriter.

The author is responsible for all statements made in his work, including changes made by the manuscript editor. Manuscripts are received with the understanding that they are not under simultaneous consideration by any other publication and have not been previously published. All manuscripts will be acknowledged, and while those rejected are generally returned to the author, the JOURNAL is not responsible in event of loss. Manuscripts accepted for publication become the property of the JOURNAL and are copyrighted by the association when published. They may not be published elsewhere without written release and permission from both the JOURNAL and the author.

All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus,* volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made after proof sheets are received by the JOURNAL.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for illustration engravings not exceeding four column inches per printed page.

Illustrations must be numbered and cited in the text. Legends, not exceeding 40 words and preferably shorter, must accompany each illustration, typed double spaced on separate sheets. The following information should appear on a gummed label affixed to the back of each illustration: Figure number, manuscript title, author's name, and arrow indicating top of the illustration.

In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

A thesis summary of 75 to 100 words must accompany each manuscript separately from the text.

Reprints may be obtained at cost plus shipping charges from the association and should be ordered prior to publication. The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. —*The Editors.*

Applications are now being accepted for scientific exhibit space for the MSMA 109th Annual Meeting to be held May 2-5, 1977, in Biloxi.

For information, write to:

Chairman, Scientific Exhibits
MSMA
P.O. Box 5229
Jackson, MS 39216

Hill Crest
HOSPITAL
Hill Crest Foundation, Inc.

A non-governmental psychiatric hospital. Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved.
Phone: 205-836-7201

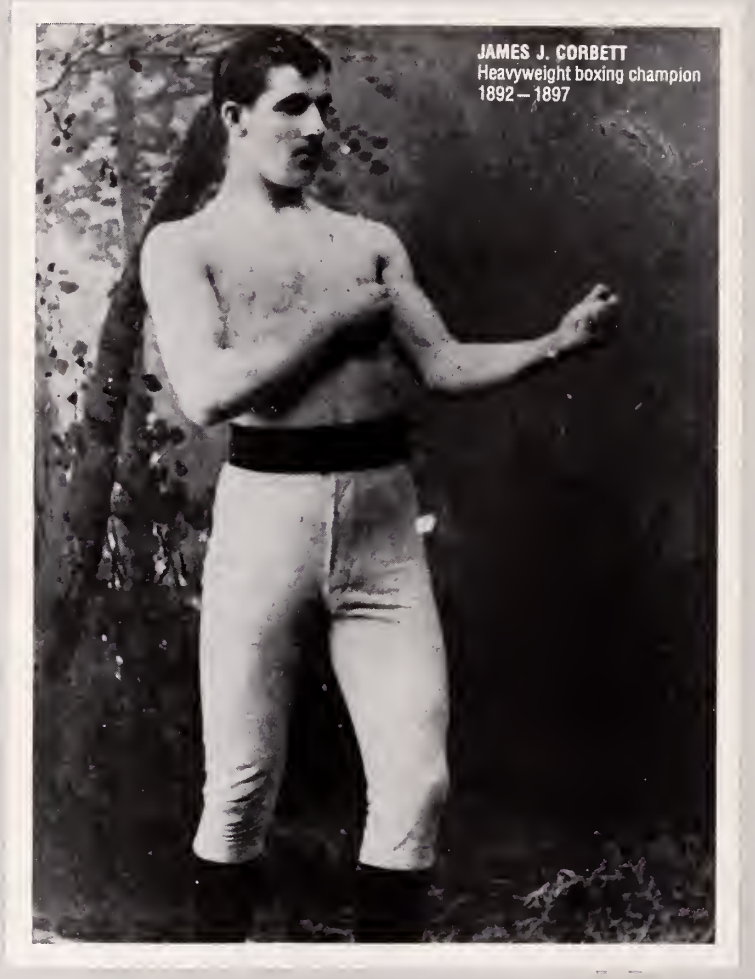


A short-term, intensive treatment center for psychiatric disorders, alcoholism, and drug abuse.

Member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Birmingham Regional Hospital Council.

6869 Fifth Avenue South
Birmingham, Alabama 35212

Famous Fighters



NEOSPORIN® Ointment
(polymyxin B-bacitracin-neomycin)
is a famous fighter, too.

Provides overlapping, broad-spectrum antibacterial action to help combat infection caused by common susceptible pathogens (including staph and strep).

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

NEWSLETTER

October 1976

Dear Doctor:

The Mississippi Advisory Council on Drug Misuse has called on State Attorney General A. F. Summer to petition the Federal Communications Commission to prohibit televised drug advertising until after 9:00 p.m. because it could "encourage drug misuse among children." The council, which passed the one-page resolution unanimously, is encouraging Summer to join the attorneys-general of 17 other states in petitioning the FCC for the limitation.

> Proponents of the measure say that four of network TV's five largest advertisers are manufacturers of over-the-counter drugs. They feel that the ready remedies shown in the TV drug ads breed false expectations toward what drugs can do for the individual.

The AMA Council on Medical Education reported to the House of Delegates at the Annual Convention that approximately 60 per cent of new medical graduates chose primary care specialties in this year's matching program. The council noted that the AMA has encouraged development of family medicine residency programs; 270 programs have been established since 1970 with 3,720 residents.

The national average time to be kept waiting in a doctor's reception room is 20 minutes, reports an AMA survey. Busy family practitioners are likely to keep patients waiting longest, an average of 27 minutes. Psychiatrists are the most prompt in keeping appointments, the AMA found. Waiting time in a psychiatry office averages 5½ minutes. Internists' patients wait 22 minutes.

The same survey found how long it takes to get an appointment with the doctor for a non-emergency health problem. The national average is 7.3 days, the AMA reported. General practitioners average 4 days' wait for an appointment. The heavily loaded practices of the obstetricians-gynecologists require the longest waiting time, 17 days, according to the survey.

New studies on acupuncture conducted at the University of North Carolina indicate that the process does not work very well in relieving pain. E. Perl, M.D., chairman of the university's department of physiology, said that while acupuncture might change the point at which some people feel pain, the change is not enough to allow painless minor surgery. Tests showed only one-third of subjects was affected.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

FAMILY PRACTICE PHYSICIANS

Openings for Family Practice Physicians in group practice. Excellent starting salary. If performance and qualifications are fulfilled, a sharing partnership is possible. Physician owned hospital adjoining. This is an opportunity to practice family medicine as training in this specialty is intended. Only U. S. medical school graduates need apply. Third year resident applications are encouraged.

Contact

John M. Canakaris, M.D.,
Bunnell General Hospital
Bunnell, Florida 32010
Telephone (904) 437-3354

THE LITTLE CARD THAT'S WORTH $2,000 INSTANT CASH, ANY TIME YOU NEED IT.



Give yourself the security, convenience and emergency protection of one of the world's most exclusive financial services—the American Express Executive Card.

Available at Jackson's warm, friendly, little bank, Fidelity Bank. We also honor Master Charge and BankAmericard.



Fidelity Bank
UTICA/JACKSON, MISSISSIPPI
MEMBER FDIC

Seminar on Pediatric Emergencies Set

Pediatric emergencies—little people, big problems will be held Nov. 21-24, 1976, Orlando Hyatt House, Orlando, FL and is sponsored by the Florida Chapter, American College of Emergency Physicians.

For further information, contact: Registrar, Pediatric Emergencies, 1919 Beachway Road, Suite 5C, Jacksonville, FL 32207, (904) 399-0510.

G.I. Disease Workshop Planned

A gastrointestinal workshop for the practicing physician is set for Dec. 17-18, 1976, at the University of Kentucky Medical Center in Lexington. Registration fee is $80.00.

For further information, contact: Frank R. Lemon, M.D., Continuing Education, College of Medicine, University of Kentucky, Lexington, KY 40506.

Republicans and Democrats Set Health Planks

Health care is a "plank" in both party platforms for this year's presidential election. The Republicans state: ". . . The Republican Party opposes compulsory national health insurance (which) will increase federal government spending by more than $70 billion in its first full year (and) require a personal income tax increase of approximately 20 per cent. We support extension of catastrophic illness protection to all who cannot obtain it. Opposes any research on live fetuses and legislation which sanctions ending life of the patients. Lower health care costs by encouraging healthier life styles, ending wasteful duplication of facilities, preventive care, more out-of-hospital service but we oppose excessive intrusions from Washington in the delivery of health care."

The Democrats state: "We need a comprehensive national health insurance system with universal and mandatory coverage (financed by) employer-employee shared payroll taxes and general tax revenues. Lower costs by government rate-setting. Rates for institutional care and physicians' service should be set in advance. . . ."



"I Cannot Tell A Lie – It Does Taste Like BANANAS!"

When acute, non-specific diarrhea causes the stomach to revolt, the tasteful counterattack is Donnagel®-PG. Donnagel-PG provides all the benefits of paregoric and—instead of that unpleasant paregoric taste—a delicious banana flavor good enough to make even an expert flip his wig.

Now with child-proof closure

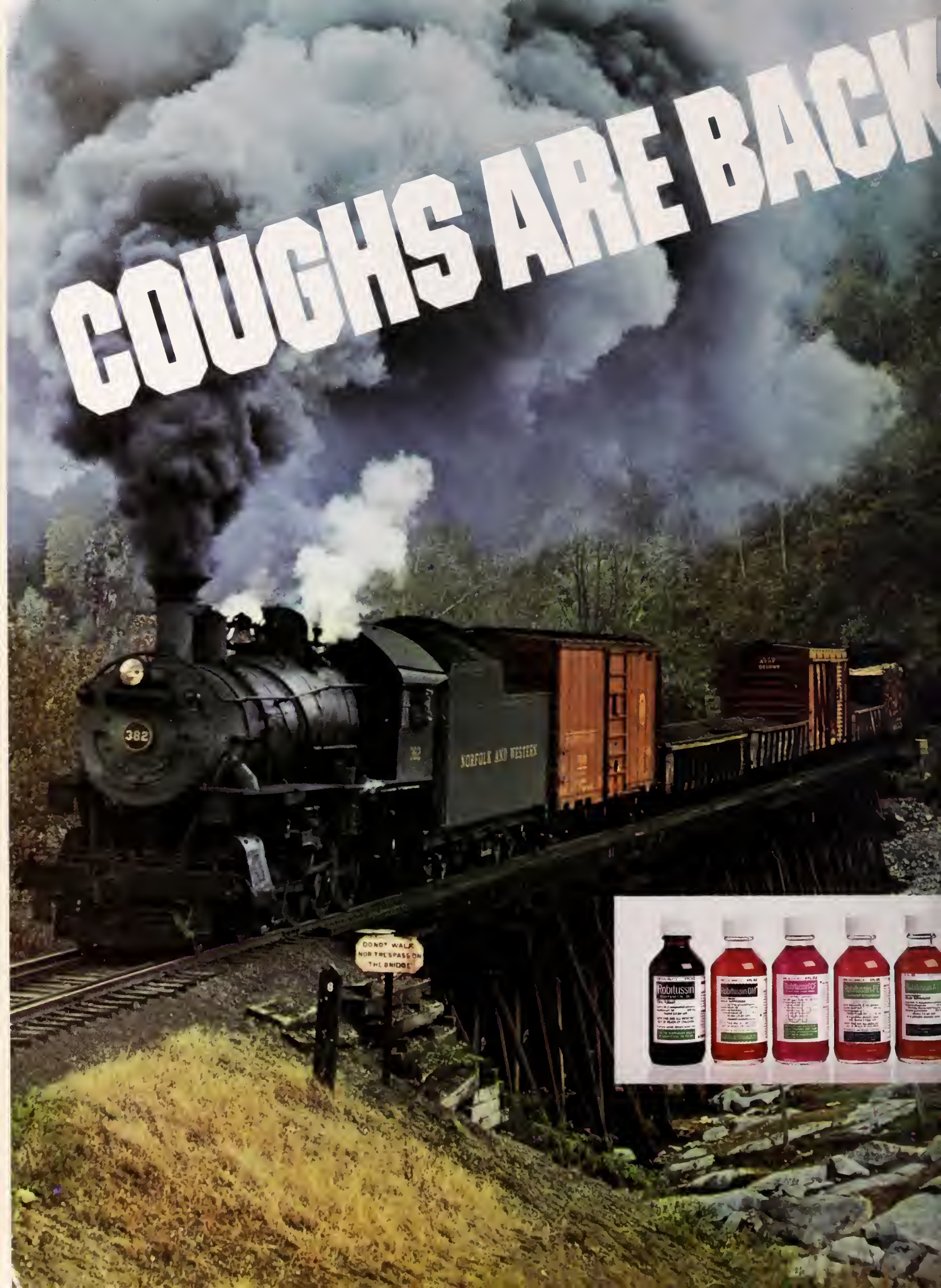
Donnagel®-PG℣

Donnagel with paregoric equivalent

For diarrhea

Each 30 ml. contains:	
Kaolin	6.0 g.
Pectin	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Powdered opium, USP (equivalent to paregoric 6 ml.) (warning: may be habit forming)	24.0 mg.
Sodium benzoate (preservative)	60.0 mg.
Alcohol, 5%	

A·H·ROBINS A.H. Robins Company, Richmond, Virginia 23220 Member of Certified Medical Representatives Institute


COUGHS ARE BACK
382
NORFOLK AND WESTERN
DO NOT WALK
NOR TRESPASS ON
THE BRIDGE
Robitussin
Robitussin DM
Robitussin-PE

CLEAR THE TRACT

in coughs of colds, "flu" and u.r.i.— clear the tract with the famous Robitussin® Line!

The 5 members of the Robitussin® family all contain the expectorant, guaifenesin, to help clear the lower respiratory tract. Guaifenesin works systemically to help stimulate the output of lower respiratory tract fluid. This enhanced flow of less viscid secretions promotes ciliary action and makes thick, inspissated mucus less viscid and easier to raise. As a result, dry, unproductive coughs become more productive and less frequent.

OUR PHOTO: Norfolk & Western Branch Train No. 202 west bound near Alvarado, Va. (Oct., 1956). This line reaches the highest point of any railroad East of the Rockies (elevation 3,577 ft.) with a minimum grade of 3%. It crosses 108 bridges, some 700 ft. long! Photo by O. Winston Link.

For productive and unproductive coughs

Robitussin®

Each 5 ml teaspoonful contains:
Guaifenesin, NF ..... 100 mg
Alcohol, 3.5%

For severe coughs

Robitussin A-C®

Each 5 ml teaspoonful contains:
Guaifenesin, NF ..... 100 mg
Codeine Phosphate, USP ..... 10.0 mg
(warning: may be habit forming)
Alcohol, 3.5%

Non narcotic for 6-8-hour cough control

Robitussin-DM®

Each 5 ml teaspoonful contains:
Guaifenesin, NF ..... 100 mg
Dextromethorphan
Hydrobromide, NF ..... 15 mg
Alcohol, 1.4%

Decongests nasal passages and sinus openings as it helps relieve coughs

Robitussin-PE®

Each 5 ml teaspoonful contains:
Guaifenesin, NF ..... 100 mg
Pseudoephedrine
Hydrochloride, NF ..... 30 mg
Alcohol, 1.4%

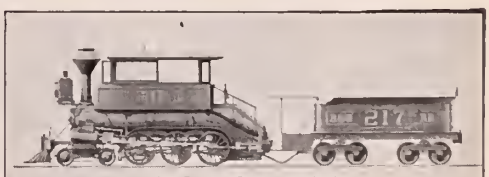
Decongestant action helps control cough and clear stuffy noses and sinuses. Non narcotic.

Robitussin-CF®

Each 5 ml teaspoonful contains:
Guaifenesin, NF ..... 50 mg
Phenylpropanolamine
Hydrochloride, NF ..... 12.5 mg
Dextromethorphan
Hydrobromide, NF ..... 10 mg
Alcohol, 1.4%

All Robitussin formulations available on your Rx or Recommendation.

For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines like the one on the preceding page. In keeping with this tradition, last year the company commissioned a well-known illustrator to render full-color drawings of several classic locomotives . . . accurate to the minutest detail. Chances are you requested and received the first locomotive in this series, The William Mason, last winter. Now, the second one is available. (See below). To order your print suitable for framing, write "Robitussin Clear-Tract Engine #2" on your Rx pad and mail to "Vintage Locomotives," Dept. T4, A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220.

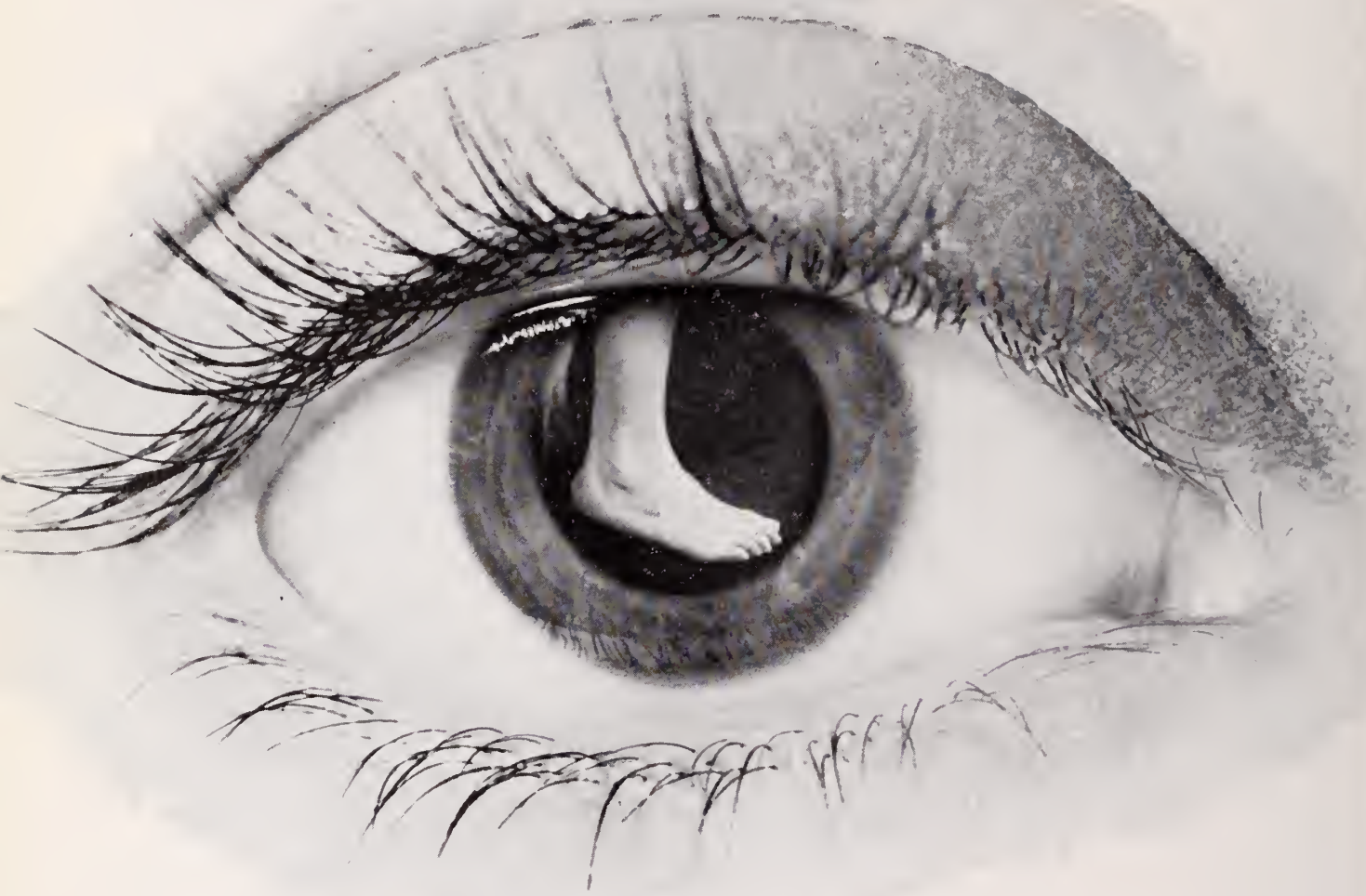


The Davis Camel (1873)

A·H·ROBINS

A. H. Robins Company, Richmond, Va. 23220

consider the effect on coexisting glaucoma when you prescribe a vasodilator*



a vasodilator that has not been reported to raise intraocular pressure

VASODILAN®
(ISOXSUPRINE HCl)

TABLETS, 20 mg.

the compatible vasodilator

Mead Johnson LABORATORIES

© 1976 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL-54118

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

DATELINE

Alcohol Pamphlet Aims at Teens

Rockville, MD - A new publication which offers factual nontechnical information about drinking to teenagers and parents is available from the National Clearinghouse for Alcohol Information. "The Drinking Question: Honest Answers to Questions Teenagers Ask About Drinking" deals with issues such as drinking and driving, teenage alcohol abuse, social aspects of drinking, parents with drinking problems, and physiological effects of alcohol. For a copy, write NCAI, Box 2345, Rockville, MD.

Heart Stress Is Reduced by Exercise

Washington, DC - Another plus for exercise -- persons who exercise probably will have an advantage over sedentary individuals when the heart is under stress, such as when a heart attack strikes. The National Society for Medical Research reports that in a recent issue of Medical World News, animal studies by a team at New York's Montefiore Hospital showed that regular exercise improves a rat's cardiac response to stress, even though it may not affect the heart's performance at rest.

Cancer Costs the Patient's Family

New York, NY - The median cost to families with cancer patients, based on an average duration of 24 months, is $19,054, according to a 1973 study of 115 families done by Cancer Care, Inc. Total cost related to the illness ranged from $5,000 to more than $50,000. Hospital and physician expenses accounted for 63.5 per cent of all costs. Other frequently reported costs included drugs, transportation, homemaker services, nursing services, equipment, treatments and lab tests.

HEW Rule-Making Is Revised

Washington, DC - David Mathews, Secretary of HEW, has announced that sweeping reforms in the department's rule-making process will give the public a bigger voice in forming social policy. Under new procedure, HEW will first publish a notice of intent to prepare regulations and seek public guidance before it writes rules. Mathews has expressed concern over HEW's wielding enormous power in writing regulations for the implementation of laws passed by Congress.

Few Research Animals Suffer

Washington, DC - Fewer than 9 per cent of the laboratory animals used in medical research during 1975 were subjected to "pain or distress," says the U.S. Department of Agriculture. In its annual report to Congress, the department stated that most experiments and tests conducted in 1975 were completed either without any painful procedures or with adequate medication for laboratory animals to eliminate pain or distress, as required by the Animal Welfare Act.

Live a little history while you learn a lot of new medicine

American Medical Association's 30th Clinical Convention December 4-7, 1976

CME
Philadelphia

CME tailored to your needs
The primary purpose of the Clinical program is to provide you with a broad-based multidisciplinary learning experience not usually available at your specialty society meetings.

The scientific program features an exceptionally large and broad selection of Category 1 courses which provide credits toward the AMA Physician's Recognition Award. In fact, the scientific program is the largest ever offered at an AMA Clinical Convention.

In Category 1, you can choose from 46 postgraduate courses, 9 general sessions, telecourses, living teaching demonstrations, and conducted exhibit rounds. In addition, Category 2 credits can be obtained by attending luncheon and "Meet the Professor" sessions.

Send for the Philadelphia Clinical CME Brochure today! It provides a complete list and description of the courses offered. Send in the coupon below today.

Dept. of Meeting Services
American Medical Association
535 N. Dearborn St.
Chicago, Ill. 60610

Please send me the Philadelphia Clinical CME brochure.

Name _____

Address _____

City _____

State/Zip _____

Virgin Isles Clinical Conference Scheduled

The second Mid-Winter Virgin Islands Clinical Conference will be held in St. Croix, Jan. 13-15, 1977, by the U. S. Virgin Islands Medical Society in association with the faculty of the University of Pennsylvania School of Medicine.

This program is acceptable for 14 credit hours in Category 1 for the Physician's Recognition Award of the AMA, and will include lectures and seminars of interest to the physician in general practice, internal medicine, general surgery, ob-gyn and pediatrics.

For further information, write airmail to James S. Glenn, M.D., F.A.C.P., Chairman, U. S Virgin Islands Medical Society, P.O. Box 520, Christiansted, St. Croix, U. S. Virgin Islands 00820.

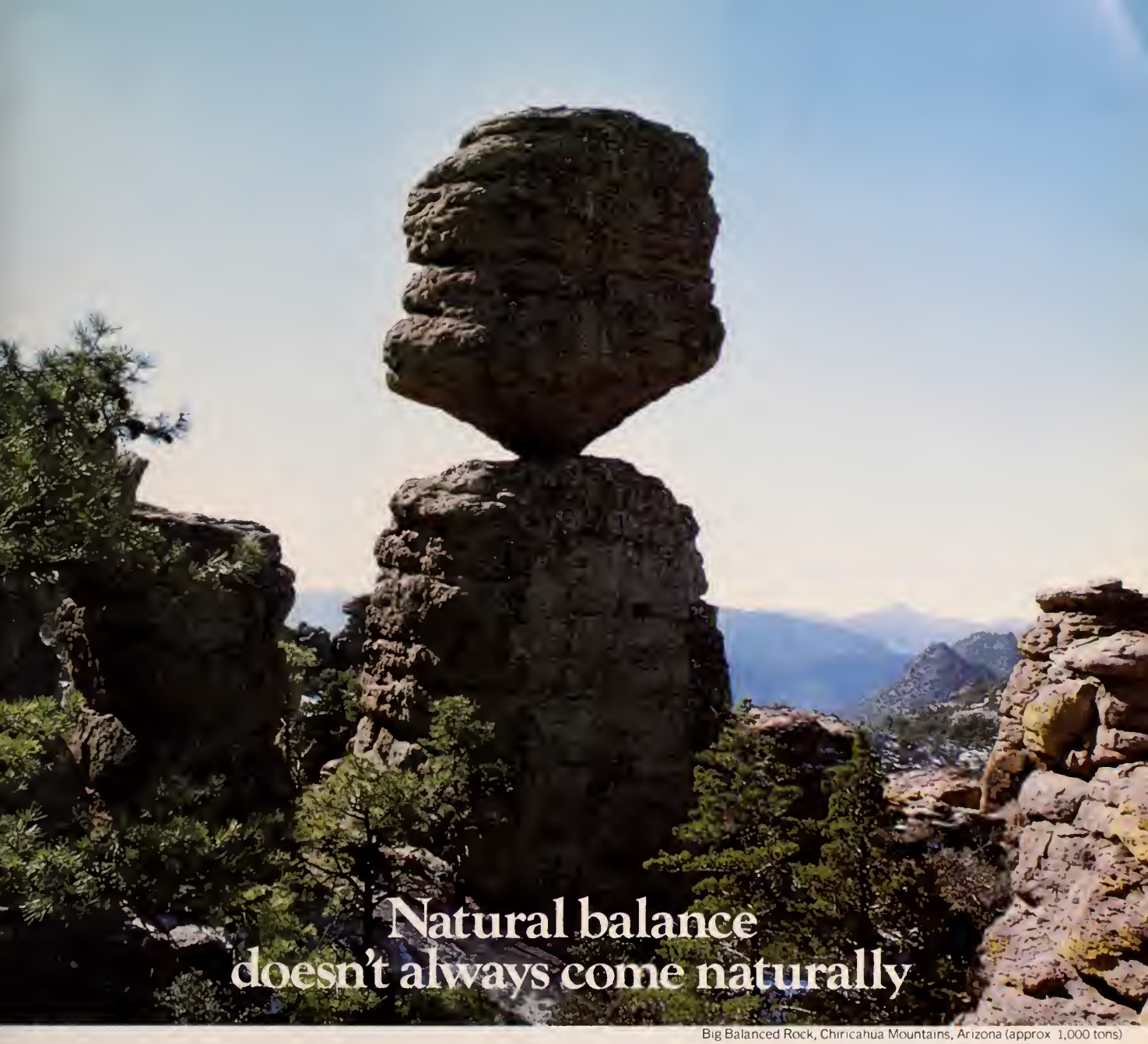
FAMILY PHYSICIANS

OAKDALE, LOUISIANA needs three Family Physicians immediately. Oakdale, population 7,500, business trade 25,000, is located in Central Louisiana near Alexandria. It is a thriving community with a diversified economic base. A new, modern equipped, 61-bed, JCAH accredited hospital completed in 1973.

FINANCIAL ASSISTANCE AND OFFICE SPACE AVAILABLE

For detailed information call collect or send Curriculum Vita, Administrator, Oakdale General Hospital, 130 North Hospital Drive, Oakdale, Louisiana 71463 (318) 335-3700.

HUMANA, INC.
THE HOSPITAL COMPANY
P.O. BOX 1438
LOUISVILLE, KY 40201



Big Balanced Rock, Chiricahua Mountains, Arizona (approx 1,000 tons)

■ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

■ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*

■ **Dosage for Vertigo*** —The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

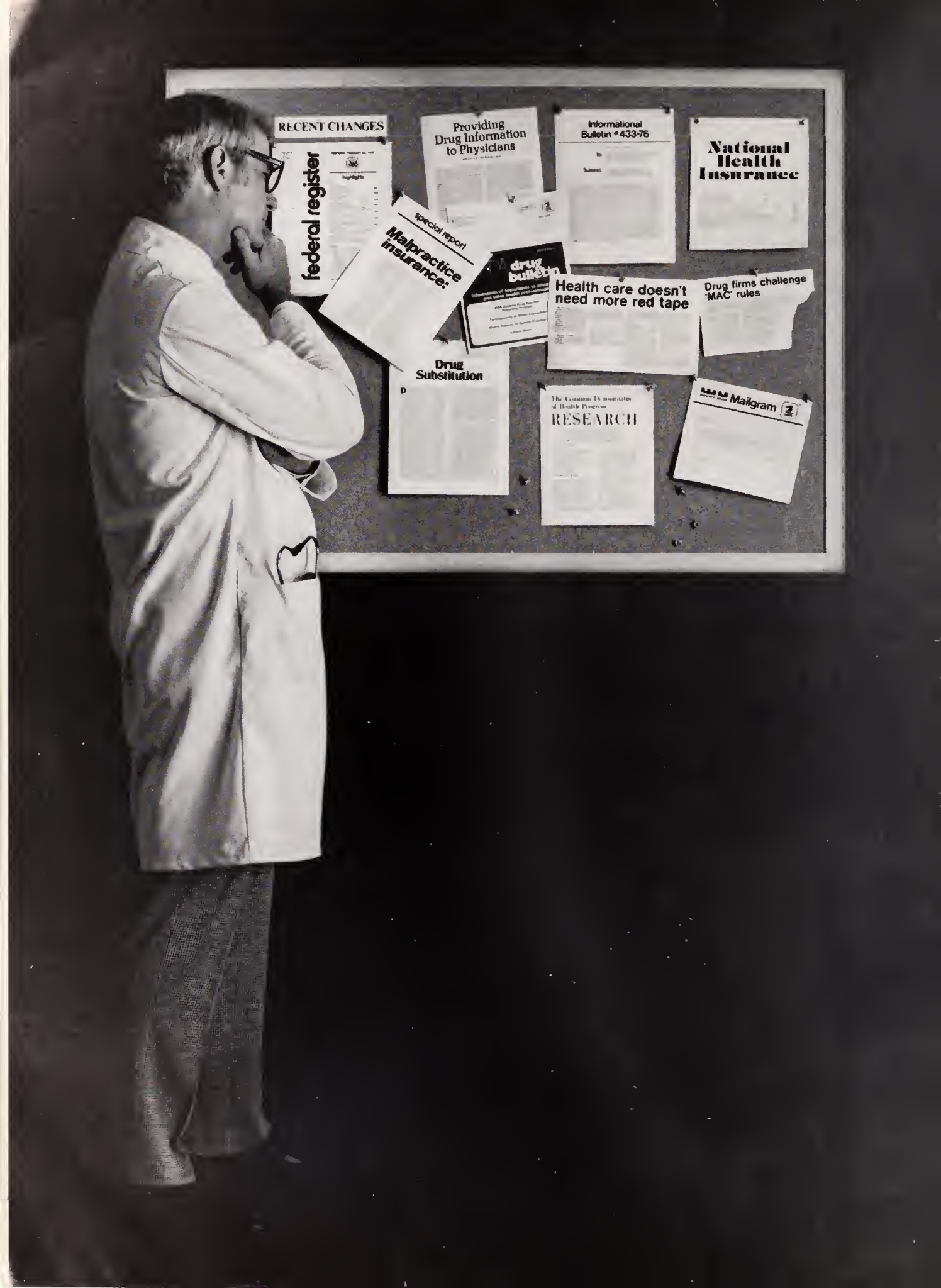
ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25

(meclizine HCl) 25 mg. Tablets
for vertigo*


RECENT CHANGES
federal register
Providing Drug Information to Physicians
Informational Bulletin #433-76
Subject
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
The Common Denominator of Health Progress
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Are Physicians Overworked?

Nearly half of the nation's doctors term their work load as "heavy," and one out of five describes that work load as "too heavy," according to a recent *AMA Impact* physician opinion poll.

Seven out of 10 physicians say they work in excess of 40 hours each week in direct patient care activities, with 46 per cent putting in a minimum of 48 hours and up to as much as 64 hours or more.

In addition, 48 per cent of the MDs report they spend another five to 10 hours weekly on practice-related activities involving paper work, while 12 per cent estimate they devote 11 to 15 hours to such chores. Seven out of 10 doctors say that their free time is so limited that they can spend less than 10 hours a week with their families.

MDs Rate High in Gallup Poll

Physicians, engineers, and college teachers are held in higher esteem than members of Congress, labor leaders, and advertising executives, according to a recent Gallup Poll.

The survey results showed that 55 per cent of those interviewed thought the honesty and ethical standards of physicians were "high" or "very high." Engineers were next with 48 per cent, and college teachers received 44 per cent.

Those polled were asked the following question: "How would you rate the honesty and ethical standards of the people in these different fields—very high, high, average, low, or very low?" The results:

Standards Are Thought to Be Very High or High

Profession	*Percentage*
Medical doctors	55
Engineers	48
College teachers	44
Journalists	33
Lawyers	25
Building contractors	22
Business executives	19
Senators	19
Congressmen	14
Labor union leaders	13
Advertising executives	11

for the inflamed phase of hemorrhoidal flare-up

ANUSOL-HC® SUPPOSITORIES
Rectal Suppositories with Hydrocortisone Acetate

ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate

CAUTION: Federal law prohibits dispensing Anusol-HC Suppositories and Anusol-HC Cream without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian Balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: bismuth subiodide, calcium phosphate, and coloring in a bland hydrogenated oil-cocoa butter base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian Balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, bismuth subiodide, propylparaben, methylparaben, polysorbate 60, sorbitan monostearate in a water-miscible base of mineral oil and glyceryl monostearate. Non-staining.

Indications: Anusol-HC is adjunctive therapy for the symptomatic relief of pain and discomfort in external and internal hemorrhoids, proctitis, papillitis, cryptitis and fissures, incomplete fistulas, and relief of local pain following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. When acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: History of sensitivity to any component. Topical corticosteroids should not be employed in tuberculous, fungal and most viral lesions of the skin (including herpes, vaccinia and varicella).

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy they should not be used unnecessarily on extended areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment. When there is bacterial skin infection, topical corticosteroids should be used only with appropriate concomitant antimicrobial therapy. Prolonged or excessive use of corticosteroids might produce systemic effects.

Dosage and Administration: Anusol-HC Suppositories: Remove foil wrapper and insert into the anus. One suppository in the morning and one at bedtime, for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol.

Anusol-HC Cream: Adults—Remove tube cap and attach the plastic applicator. After gentle bathing and drying of the area, apply to the exterior surface and gently rub in. For internal use, insert the applicator by applying gentle, continuous pressure. Then squeeze tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol.

Supplied: Anusol-HC Suppositories—boxes of 12 (N 0047-0089-12) suppositories in silver foil strips with (W|C) printed in black.

Anusol-HC Cream—one-ounce tube (N 0047-0090-01) with plastic applicator; detachable label.

Full information is available on request.

Warner/Chilcott
(W|C) Division, Warner-Lambert Company, Morris Plains, New Jersey 07950

AN-GP-51-4C

THE PROFESSIONAL SOURCE OF

COMFORT

FOR INTERNAL & EXTERNAL ANORECTAL CONDITIONS

Anusol-HC®

suppositories and cream
with hydrocortisone acetate. Rx only

pain and burning respond in minutes

- without belladonna alkaloids
- without CNS stimulants



Artist's interpretation in bas-relief of external hemorrhoids, postoperative anorectal wounds and anal dermatitis.

TO COMPLETE YOUR HEALTH INSURANCE PICTURE, MSMA OFFERS ITS NEW COMPLETE HEALTH INSURANCE PACKAGE:

NEW MAJOR MEDICAL PLAN

Covers 80% of your eligible expenses after you satisfy your deductible amount. Choice of deductibles available. Pays expenses in and out of the hospital!

NEW HOSPITAL MONEY PLAN®

Pays a daily benefit for each day you spend in the hospital because of an accident or illness. Acceptance is GUARANTEED! Pays the benefits directly to *you*!

NEW EXCESS MAJOR MEDICAL PLAN

Picks up where basic insurance programs leave off. Pays 100% of eligible expenses in or out of the hospital—up to $250,000 maximum. And, premiums are LOW! Acceptance is GUARANTEED!

A complete health insurance picture is probably one of the most important items you can provide for your family's financial well-being. To help you combat the rising cost of hospital and medical care, MSMA has entirely revamped its health insurance program to give you the most complete and comprehensive program available . . . and at a low price all can appreciate. Find out more. Mail the coupon below for more information:

THE MSMA INSURANCE PROGRAMS ARE UNDERWRITTEN BY:

CONTINENTAL CASUALTY Co.
ASSOCIATION GROUP DIVISION
Chicago, IL 60685

a division of CNA/insurance

Please send me more details on the NEW MSMA insurance programs:

☐ **MSMA MAJOR MEDICAL PLAN** ☐ **MSMA HOSPITAL MONEY PLAN** ☐ **MSMA EXCESS MAJOR MEDICAL PLAN**

NAME_____

ADDRESS_____

CITY_____

STATE_____ ZIP CODE_____

MAIL TO: Thomas Yates & Co., MSMA Insurance Administrators
P.O. Box 1054, Jackson, Mississippi 39205

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
October 1976, Vol. XVII, No. 10

ORIGINAL PAPERS

What the Internist Should Know About Echocardiography

STEPHEN P. GLASSER, M.D.
Shreveport, Louisiana

The author gives the history of development of echocardiography, the advantages and disadvantages of the procedure. He says that echocardiography use is important in the following conditions: valvular heart disease, pericardial disease, heart muscle disease, and congenital heart disease. Echocardiography has taken its place in the diagnosis and evaluation of cardiac disorders and stands next to electrocardiography and cardiac catheterization, according to Dr. Glasser.

ECHOCARDIOGRAPHY descended from independent research done in France, Britain and Germany during the mid-nineteenth century on the Piezo electric properties of crystalline quartz. Piezo electric material has the property of expanding and contracting when placed under the influence of an electronic impulse and also possesses the ability to reverse this process. The frequency of this process is a property of the crystal itself. The physical principles of sound in general govern ultrasonics. Ultrasound is defined as frequencies above 20,000 cycles per second (Hertz). Edler and Hertz in Sweden and Effert in Germany in the 1950's were the pioneers of ultrasound studies in man although the concept itself was used following WWI in the development of sonar for the Navy's anti-submarine warfare program. In the past 10 years ultrasound study of the heart (echocardiography) has blossomed into a valuable and full fledged specialty.

The ultrasound frequency used in cardiac echography is in the range of one million to five million Hertz (1-5 megaHz). Most commercially available instruments produce a one microsecond pulse of approximately 0.01 watt/cm^2, a level at least 1000 times less than that which produces any tissue damage. The same transducer then receives the returning signals for the remaining 999 microseconds. The sound pulse travels out as a beam with partial reflectance of the sound at each interface previously determined by the "acoustic density" of the interface and the angle at which the sound wave strikes the interface. Since the speed of sound in most soft tissue travels within a very narrow range, the time from pulse generation to reception of each returning echo allows calculation of the distance from the transducer to the reflecting interface. Thus, "depth readings" are made 999 times per second with the reflecting interfaces displayed with distance from the transducer on the ordinant and time on the abscissa. A calibration grid with 1 cm markers and time markers are placed on the record. Echo intensity is represented by signal brightness on the oscilloscope display.

Early in vitro experiments and the more recent discovery of echographic indicators (such as indocyanine green) have allowed for a high degree of confidence in the identification of intracardiac structures. Interpretation of the echographic patterns from these structures requires correlation with pathophysiologic states. Like electrocardiography, interpretation is best performed when the interpreter is thor-

Presented at the Mississippi-Louisiana Regional Meeting of the American College of Physicians, Jackson, MS, Jan. 1976.
From the Cardiology Section, Louisiana State University Medical Center, School of Medicine in Shreveport, Shreveport, La.

oughly familiar with the patient's problems. Unlike electrocardiography, echocardiographic technique is not learned simply and results depend to a large extent upon the technical performance of the procedure. In general, the advantages and disadvantages of echocardiography are listed in Table I.

TABLE I

Advantages
Convenience—it can be performed on an outpatient basis or at the patient's bedside
It is a non-invasive technique
No toxicity or radiation hazard is present
It can be repeated frequently
The expense of an examination is relatively small
Disadvantages
The initial expense of the equipment is relatively high
The technique requires that a technician has had at least 3-6 months of specialized training in order to do just the routine exams
Invasive studies may still be required
Certain patients are technically impossible to study including many patients with pectus deformities of the chest wall, emphysematous patients and extremely obese individuals

With these principles in mind we can now turn to a discussion of the proven and practical uses of echocardiography important to the practicing internist. Broadly speaking, useful information can be obtained in the conditions listed in Table II.

TABLE II

Valvular Heart Disease
valve leaflet motion
severity of obstruction
chamber dimensions
Pericardial Disease
Heart Muscle Disease
regional wall motion
chamber dimension
ventricular performance
Congenital Heart Disease
septal motion
shunt localization
chamber dimension
great vessel anatomy
Miscellaneous Conditions
left atrial myxoma
hypertrophic subaortic stenosis

Valvular Heart Disease: Various types of valvular heart disease can be identified by echographic techniques and in general some estimation of severity can be made. The application of diagnostic ultrasound for detecting mitral stenosis has been exceedingly useful in the quantitative assessment of this lesion. The diastolic slope of the mitral valve has been found to correlate with the degree of obstruction and the amplitude of movement correlates with valvular pliability (see Figures 1A & 1B). A number of conditions may simulate the echographic pattern of mitral stenosis but these can generally be differentiated by the experienced echocardiographer. Post mitral valvotomy, echocardiography can be utilized (particularly in a serial fashion) to follow such patients for the effectiveness of surgery and in evaluating patients for re-stenosis.

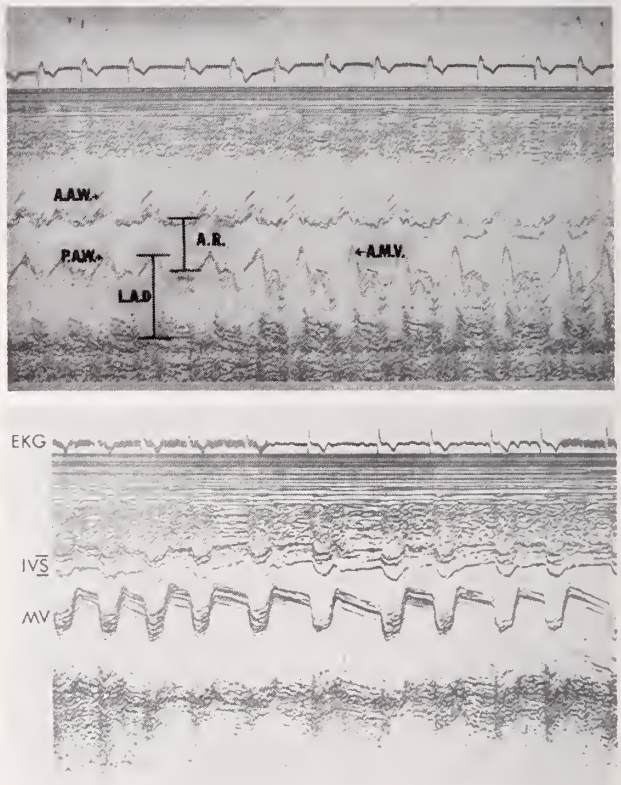


Figure 1. Compares normal mitral valve motion (A) with the mitral echo obtained from a patient with mitral stenosis (1B). EKG = electrocardiogram used for reference. IVS = intraventricular septum. CW = chest wall. AMV is the anterior mitral valve leaflet; PMV, posterior mitral valve leaflet. a, b, c, d, e, f are standard points of reference. Note the sharp peaks and valleys of the normal MV motion versus the "square wave" configuration of mitral stenosis.

Author's Note: (L.A.D. = Left Atrial Dimension; A.R. = Aortic Root Dimension; A.M.V. = Anterior Leaflet, Mitral Valve; A.A.W. = Anterior Aortic Wall; P.A.W. = Posterior Aortic Wall.)

In mitral regurgitation echocardiography can be utilized to measure chamber size (left ventricular and left atrial dimensions are easily obtained) and muscle thickness in order to help estimate severity and left ventricular function. Additionally, echocardiography may aid in etiologic determination. In patients with suspected mitral prolapse syndrome a

characteristic defect on echography is seen (see Figure 2). Since these patients may be prone to life threatening ventricular arrhythmia and sudden death, identification of these subjects may be important. Additionally, characteristic defects may be seen in patients with ruptured chordae tendinae, papillary muscle rupture and bacterial endocarditis.



Figure 2. AMV = anterior mitral valve, P = prolapse. Here the systolic MV motion is posterior rather than the normal anterior motion (see Figure 1A).

Echocardiography does not as easily identify aortic valve disease but nonetheless may frequently prove helpful. Thus, the identification of bicuspid or congenitally deformed aortic valve leaflets may be determined early in life even before obstruction is present (see Figure 3). Often enough, the severity of obstruction can also be evaluated. In aortic regurgitation the etiology and severity can be estimated primarily by indirect signs. Thus, dilatation of the ascending aorta can in general be easily diagnosed and suggests aortic root disease as the cause of aortic regurgitation. Left ventricular cavity enlargement indicates severity and a characteristic fluttering of the anterior mitral leaflet coincides with auscultatory evidence of an Austin-Flint murmur and when associated mitral stenosis has been incorrectly considered is easily differentiated (see Figure 4).

Pericardial Disease: The detection of pericardial effusion by reflected ultrasound has been very reliable and is probably one of the first clinical uses of ultrasound. The most striking finding is an echo-free space (pericardial fluid) between the posterior epicardium and the pericardium (see Figure 5). The diagnostic accuracy has been proven and echography would appear preferable to carbon monoxide or radioisotope studies. Quantification of the amount of fluid is not easy and can be only estimated, but when tamponade occurs additional features suggest that diagnosis.

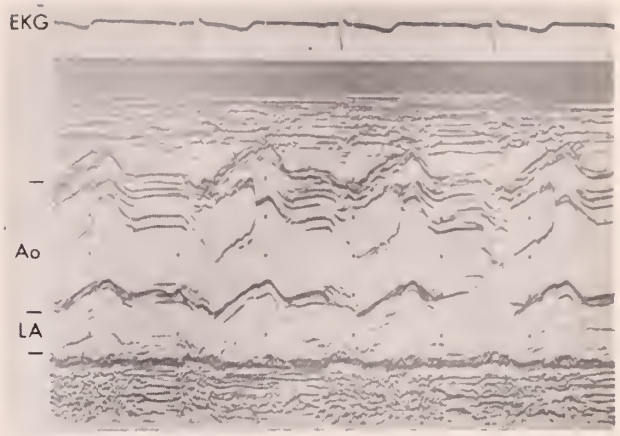


Figure 3. EKG = electrocardiogram, AO = aorta, LA = left atrium. A boxlike opening is seen in the aorta and represents aortic valve leaflets. These are eccentric in location since the aortic leaflets should be located centrally within the aortic root.

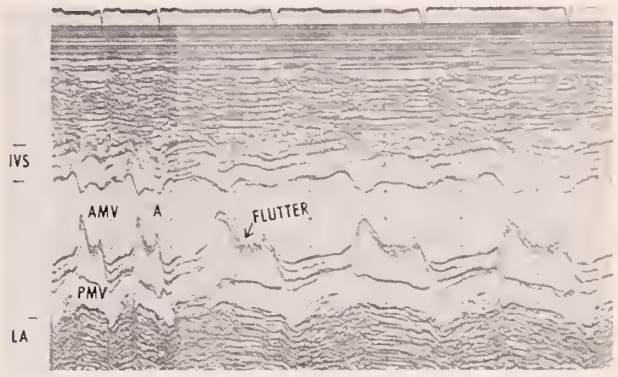


Figure 4. IVS = interventricular septum, LA = left atrium, AMV = anterior mitral valve, PMV = posterior mitral valve, A = mitral valve opening secondary to atrial contraction. This tracing demonstrates normal anterior and posterior mitral motion except for the fine fluttering motion of the AMV seen commonly in aortic regurgitation.

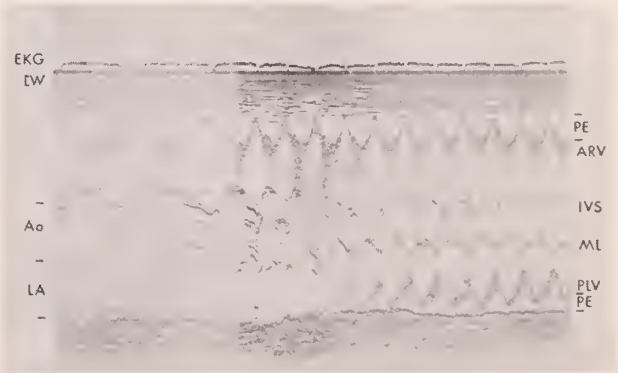


Figure 5. EKG = electrocardiogram, CW = chest wall, AO = aorta, LA = left atrium, ARV = anterior right ventricular wall, PLV = posterior left ventricular wall, IVS = interventricular septum, ML = mitral leaflet. AE and PE = anterior and posterior pericardial effusion. This represents a fairly large malignant pericardial effusion.

Heart Muscle Disease: In this common group of disorders, echocardiography is helpful in evaluating an enlarged heart since unsuspected pericardial effusion, valvular heart disease and some congenital defects (e.g. atrial septal defect) may be found. In primary cardiomyopathy echocardiographic features are nonspecific but useful information can still be obtained. For example, severity can be estimated by wall motion and chamber size and even stroke volume and ejection fraction can be approximated. These have in general been shown to correlate with angiographic determinations. Segmental abnormalities, on the other hand, suggest coronary artery disease with akinesia.

Congenital Heart Disease: Pediatric echocardiography is now undergoing the same volcanic explosion in knowledge that adult ultrasound underwent five years ago. However, for the practicing internist the most important congenital defect is undoubtedly atrial septal defect (ASD), not only because this is a potentially curable lesion but because its clinical findings in younger life are often subtle and because its classic features in older life may be masked. Its echo diagnosis is based on somewhat indirect evidence since the atrial septum itself cannot be reliably echoed by conventional techniques. Rather, it has been found that intraventricular septal motion in right ventricular volume overload states results in paradoxic ventricular septal motion. Other causes of right ventricular volume overload are much less common and/or can be ruled out clinically but cause the same echographic abnormality.

Miscellaneous Conditions: Many other conditions can be diagnosed by echocardiography, information obtained about severity, or a differential diagnosis may be narrowed. However, these are beyond the scope of this presentation. Two such conditions warrant special note, however. One is left atrial myxoma, the other idiopathic hypertrophic subaortic stenosis. The cavity of the left atrium is by and large echo free. When a space occupying lesion is present (left atrial myxoma, thrombus, etc.) a dense return of echoes is visualized. In general this presents a very characteristic echographic picture and any patient with unusual features of mitral stenosis or regurgitation, changing murmurs, fever of undetermined origin, etc. should be referred for ultrasound examination (see Figure 6). Likewise, any patient with even remotely suggestive features of IHSS should have echocardiographic examination since its echographic features are also characteristic. This would include younger individuals with angina or patients with a family history of IHSS or symptoms suggestive of this disorder. In fact even asymptomatic members of families with suggestive or diagnosed IHSS should be studied. Here, the echographic features include systolic anterior motion (SAM) of the anterior mitral leaflet (probably due to the Venturi effect) along with asymmetric septal hypertrophy (ASH). That is, if one compares the ratio of thickness of the interventricular septum to that of the posterior left ventricular wall it is greater than 1.3:1.

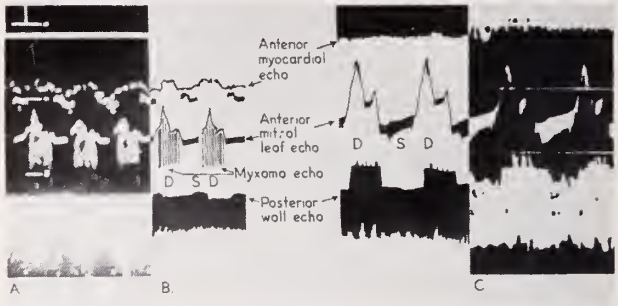


Figure 6. A Represents a preoperative actual and schematic mitral valve echogram. Posterior to the mitral valve is an echo dense mass subsequently shown to be a left atrial myxoma. B represents the schematic and actual mitral valve echogram obtained postoperatively. Note the absence of the echo dense mass. D = diastole, S = systole.

Future Horizons: To this point I have primarily discussed the M mode presentation of ultrasound. That is, the transducer is held at a stationary point on the chest wall and cardiac structures are recorded relative to that point and swept across an oscilloscope with an "ice pick" view of the heart obtained. The newer technique of two dimensional sector scanning is now being refined and although still in the experimental stages should add more to our ability to non-invasively study cardiac structures. One area where this technique is already useful is in the study of left ventricular motion in coronary artery disease and the identification of akinesia.

Overall, echocardiography has taken its place in the diagnosis and evaluation of cardiac disorders and stands next to electrocardiography and cardiac catheterization. ★★★

Dr. Glasser has since moved to VA Hospital, 13000 N. 30th St., Tampa, FL (33612).

REFERENCES

1. Fortuin, N. J.: Echocardiography: What It Can Do Now. Hospital Practice, November 1975, pp. 73-80.
2. Pridie, R. B., Behnam, R. and Wild, J.: Ultrasound in Cardiac Diagnosis. Clin. Radiol. 23:160-173, 1972.
3. Feigenbaum, H.: Newer Aspects of Echocardiography. Circulation XLVII: 833-842, April 1973.
4. Segal, B. L., Konechke, L. L., Kawai, N., Kotler, M. N. and Linhart, J. W.: Echocardiography, Current Concepts and Clinical Application. Amer. J. Med. 57:267-283, August 1974.

Intermittent Positive Pressure Breathing: Good Medicine or Gadgetry?

W. BROOKS EMORY, M.D.
New Orleans, Louisiana

INTERMITTENT positive pressure breathing (IPPB) devices and a team of respiratory therapists are synonymous with the modern medical care of patients with respiratory diseases. Emphysematous or asthmatic patients, as well as almost all postoperative patients, are treated at one time or another with IPPB devices in order to deliver aerosol medications, improve minute ventilation, or treat postoperative alveolar collapse. Please notice that I use the term "modern" medical care and not "good" medical care, because recently the negative evaluation of IPPB made in the early 1960's is again resurfacing, and once again respiratory physiologists and chest physicians are questioning the efficacy of its routine use (see Table I).

Positive pressure breathing is a non-physiologic means of delivering a volume of gas (usually air or oxygen-enriched air) to the upper airway. The old fashioned Drinker respirator, iron lung, and cuirass are physiologic in design but undesirable because they limit access to the patient for nursing and medical care. In contrast, the ease of setup and operation of the IPPB machine, the simplification of controls, combined with the marketing programs of Bird, Bennett, Monahan, and others have caused the astronomical proliferation of a form of treatment that has limited indications. In many instances, patients with "steady state" chronic obstructive pulmonary disease (COPD) are treated with IPPB in the hospital. This has induced them to purchase or rent these devices for home use regardless of actual need.

The most exploitative use of IPPB devices is in the deliverance of aerosols of water, saline, mucolytic agents and drugs. In my opinion, aerosolized bronchodilators are equally as well delivered with a hand-bulb nebulizer or routine aerosol adapter. Intermittent positive pressure, delivered to the upper airway, is not necessary to deliver aerosols. We are led to believe by the sales representatives that aerosol particles are deposited on the respiratory bronchioles by impaction and work directly. However, radioisotope studies[1] show that the bulk of material is impacted in the posterior pharynx where it is absorbed and delivered via the blood stream to the site of action. It never reaches the distal respiratory tract directly. If we consider the relative expense of these two means of delivering an aerosol bronchodilator, particularly accepting the premise that a glass bulb nebulizer is equally as effective, then the IPPB is unacceptable.

Intermittent positive pressure breathing devices are widely used to treat postoperative patients and those with respiratory diseases. Studies have indicated that some of the suggested therapeutic effects are of questionable benefit and the treatment has several known adverse effects. For these reasons, the treatment should be re-examined and not routinely prescribed.

It is claimed that IPPB will aid the patient with severe obstructive lung disease by improving alveolar ventilation and hence reduce the elevated PCO_2 and raise the resting PO_2. In "steady state" obstructive pulmonary disease, IPPB generally produces hyperventilation that is less costly in terms of oxygen consumption than comparable voluntary hyperventilation. However, in an uncooperative patient, the work of breathing actually increases with IPPB because the patient does not relax his inspiratory muscles during the inspiratory phases of cycle and must terminate inspiration by an active and an expensive expiratory effort. The only rationale for a continued beneficial effect is that closed airways, once opened, may stay open for some time. In normal persons airway closure usually occurs within the first 30 to 60 minutes after a deep breath.[2] One wonders how IPPB therapy, two to four times a day for short periods of time, can have any substantial effect on overall breathing function.

Presented at the Mississippi-Louisiana Regional Meeting of the American College of Physicians, Jackson, Ms, Jan. 1976.

From the Department of Internal Medicine, Section on Pulmonary Diseases, Ochsner Medical Center, New Orleans, La.

Thornton and colleagues[3] administered IPPB every waking hour for 14 days to 17 patients with steady state COPD. They found no improvement in blood gases, A-A gradient, lung volumes, or FEV_1 values. Kamat and others[4] reported in 1962 that patients with severe obstructive lung disease did not benefit from the routine employment of IPPB in the management of their disease. The longterm use of IPPB in a selected group with pulmonary disease resulted in a more rapid deterioration in lung function as reflected in a 90 cc per year deterioration in FEV_1 values. A matched group of controls untreated with IPPB but with the same bronchodilators and expectorants showed a deterioration of only approximately 44 cc per year. Finally, Curtis and co-workers[5] compared a group of 78 patients who used IPPB at home with a control group of 109; the mean time of followup in this study was more than four years. The patients given IPPB were sicker than the control group in terms of vital capacity and FEV_1 deterioration, and there was no appreciable change in blood gases in either group. Since IPPB is used for brief periods at intervals during the day, its effect on blood gases is transient, and neither hypoxia nor CO_2 retention is considered an indication for IPPB in patients with stable COPD. Thus, IPPB fails to prevent progressive deterioration in lung function and may actually hasten it for as yet unexplained reasons.

TABLE I

ADVERSE RESPONSES TO INTERMITTENT POSITIVE PRESSURE BREATHING

1. CO_2 narcosis
2. Decreased cardiac output
3. Pneumothorax
4. Sympathomimetic effects
5. Mucosal drying and irritation
6. Marked increase in dyspnea
7. Nosocomial infection
8. More rapid deterioration of lung function
9. Psychological dependency

Intermittent positive pressure breathing is a routine postoperative order in many hospitals. At the meeting of the American College of Surgeons in San Francisco in the fall of 1975, Browner and Powers reported their experience with the routine administration of postoperative IPPB for 13 patients. They concluded that oxygen is delivered down a path of least resistance, expanding already open alveoli, and shutting the compromised alveoli. A similar conclusion was reported by Sands, et al[6] in 1961. They showed that the incidence of postoperative pneumonia or atelectasis was not altered by IPPB therapy in patients after routine abdominal or thoracic operations. At our institution, we are presently monitoring postoperative patients to see if their vital capacity is augmented by the use of IPPB. Only 20 to 30 per cent of patients show any increase in vital capacity after a breathing treatment. The implication is that a certain percentage of patients do improve their vital capacity after breathing therapy, but they must be individualized and pre- and post-treatment assessment should be performed to determine if the therapy has any validity in that particular patient.

In addition to these questionable therapeutic effects, IPPB has some known adverse effects. Patients with obstructive lung disease have increased airway resistance and exceedingly low flow rates must be used during IPPB treatments. At high flow rates, resistance rises rapidly, the machine cycles off, and a suitable tidal volume is not delivered to the patient. Another real hazard is that all pressure cycle devices are powered by a gas pressure source. In most hospitals oxygen is delivered from the wall at an oxygen concentration of 100 per cent at 50 pounds per square inch; unless specifically prescribed, the patient will receive 100 per cent oxygen during all breathing treatments. In patients who have obstructive lung disease, uncontrolled oxygen can be a most dangerous drug. An air-mix valve may be used to dilute the oxygen concentration, but the lowest concentration possible is still 40 per cent oxygen. A 40 per cent oxygen concentration in a person with carbon dioxide retention can lead to hypoventilation and further carbon dioxide retention. In addition, the venturigate, as it is called, closes when 15 cm of water pressure is achieved at the mouth, a pressure that is easily achieved since many breathing treatments require mouth pressures up to 30 cm of water and the pressure in a healthy person is somewhere between 10 and 20 cm of water. In this case, the venturigate closes and the patient is inspiring 100 per cent oxygen during that phase of the inspiratory cycle.

Certain patients with COPD will develop alveolar hypoventilation despite an increase in overall minute ventilation because of an increase in the dead space-tidal volume ratio due to induced hyperventilation.

The effects on the cardiovascular system secondary to the increase in positive pressure in the intrathoracic cavity are many. A decreased venous return to the right heart occurs, with a secondary fall-off in cardiac output. Pneumothorax, a complication of all forms of ventilatory therapy, may occur. The

drying and irritative effect of aerosols, when not properly humidified, can result in buildup in bronchial secretion and aggravate the underlying condition. The sympathomimetic amine of the bronchodilator solution often results in tachycardia and hyperexcitability.

The risk of infection is high, particularly in patients who use devices at home and do not practice meticulous cleaning techniques. The infecting organisms are often gram-negative and hence quite devastating to persons who have underlying lung disease. We routinely culture the breathing devices of patients that we see in consultation and it is amazing the number and type of bacteria found in the "cleanest device."

Another adverse effect of IPPB is the strong psychological dependence developed in the patient. Patients with the most severe form of pulmonary emphysema, who are the most vulnerable to the other adverse side effects, are the most likely to develop psychological dependence on the machine.

SUMMARY

To summarize, it is time to reexamine IPPB as a routine treatment of postoperative patients and patients with chronic obstructive pulmonary disease. Are we justified in spending two billion dollars a year on a therapeutic modality of questionable efficacy with known complications? What we do need is a comprehensive treatment program to help patients with chronic obstructive pulmonary disease and better postoperative nursing care. What we do not need is more and more reliance on gadgetry, while calling it "science." ★★★

1516 Jefferson Highway (70121)

REFERENCES

1. Blackwell, E. W., Connolly, M. E., Davies, D. S. et al: The Fate of Isoprenaline Administered by Pressurized Aerosols. Br. J. Pharmacol. 39:194P-195P, 1970.
2. Ferris, B. G. Jr. and Pollard, D. S.: Effect of Deep and Quiet Breathing in Pulmonary Compliance in Man. J. Clin. Invest. 39:143-149, 1960.
3. Thornton, J. A., Darke, C. S. and Herbert, P.: Intermittent Positive Pressure Breathing (IPPB) in Chronic Respiratory Disease. Anesthesia 29:44-49, 1974.
4. Kamat, S. R., Dufano, M. J. and Segal, M. S.: The effects of Intermittent Positive Pressure Breathing (IPPB) With Compressed Air in Patients With Severe Chronic Nonspecific Obstructive Pulmonary Disease. Am. Rev. Resp. Dis. 86:360-380, 1962.
5. Curtis, J. K., Liska, A. P., Rasmussen, H. K. et al: IPPB Therapy in Chronic Obstructive Pulmonary Disease. JAMA 206:1037-1040, 1968.
6. Sands, J. H., Cypert, C., Armstrong, R. et al: A Controlled Study Using Routine Intermittent Positive Pressure Breathing in the Post-Surgical Patient. Dis. Chest 40:128-133, 1961.

DID YOU KNOW?

- About 1 in 7 Americans will be admitted to a hospital by year's end.
- The average man loses slightly less time from work than the average woman, because of acute conditions.
- Americans make more than one billion visits to physicians a year, an average of about five visits per person.
- About 7 in 10 persons in the U. S. see or talk to a physician within a year.
- About 1 in 7 Americans has not visited a doctor in more than two years.
- About 1 in 100 Americans has never visited a doctor.

—Health Insurance Institute

You Could Have Been a Steam Doctor

LESLIE CAINE CAMPBELL
Auburn, Alabama

Almost-forgotten incidents in the history of medicine in Mississippi are recalled as examples in this Bicentennial synopsis of American medical practice. The narrative calls to mind how radically the knowledge and methods of American physicians have advanced since 1776. The record of medical care in these two centuries bears testimony to the resilience of the human being, who has endured so much from both disease and doctor, and to the improvements in medical practice that have been made through education, and persistence, and purposeful cultivation of creative genius.

A PHYSICIAN WAS making his rounds in Lowndes County, Mississippi, one day in 1834. He reined in his horse at a spot near Columbus and dismounted. The horse was burdened with two saddle bags. With great emotion and with determination the doctor dumped the contents of one saddle bag on the ground. Leaving the other saddle bag untouched, he remounted his horse and continued on his way. Who was this man? How had he come to be here? What was in the saddlebags? What was the offending content of the bag that he discarded? What significance did it have for medicine in Mississippi, and Louisiana, and America?

The motives of that solitary rider stemmed directly from his own experiences in frontier Mississippi; in part, too, his actions owned a distant provenance in the medical career of Benjamin Rush.

Benjamin Rush has long been the most celebrated of colonial and revolutionary era American physicians. The Bicentennial observance has intensified interest in him, all the more so because he was actively engaged in politics and in the fight for independence. He was one of four doctors who signed the Declaration of Independence. He perhaps was a minor figure in the appointment of George Washington as commander-in-chief of the American army. He provided Thomas Paine the title, the urging, and the location of a printer for the pamphlet *Common Sense*. He gained reform in the Continental Army's medical system through his position in Congress. As a member of the Pennsylvania ratifying convention he was one of the leaders in getting the United States Constitution adopted.

In his general accomplishments in health care he was deserving of praise. He established the first free dispensary in the United States. His book, *Medical Inquiries and Observations Upon the Diseases of the Mind,* 1812, contained much of value, and he was an effective leader in gaining better care for the mentally ill.

As a spinner of medical theories and as a practicing physician, on the other hand, he was an abomination. In the United States and most of the western world, with the exception of France, attempts to explain disease in the late eighteenth and early nineteenth centuries were along theoretical lines, in terms of humoralism, miasmata, or "some other ingenious dream." This nebulous theorizing could harm no one in itself. In the hands of Benjamin Rush, however, causative theory was coupled with a curative theory of astounding stringency. Rush theorized that "vascular tension" was the underlying cause of all disease. His remedy was the evacuation of blood, in some cases as much as 80 per cent of the blood in a patient's body. Other standard practices of the regular physicians of the time were blistering, purging, vomiting, sweating, and the use of large doses of mineral agents, particularly mercury.

In the 1820s the disciplines of Benjamin Rush remained basically intact in the medical teachings at Transylvania University in Lexington, Ky. John Wesley Monette entered Transylvania from Washington, Mississippi, and was graduated in 1825. This 22-year-old physician applied the "heroic" measures of Benjamin Rush in his Mississippi practice. The case of Monette is simply an example of how Rush's doctrine came to Mississippi. It also made its way to the state through other medical schools and through numerous publications.

Presented at the Mississippi-Louisiana Regional Meeting of the American College of Physicians, Jackson, MS, Jan. 1976.

Associate Dean, Auburn University, Auburn, AL.

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, June 26-July 1, Dallas. Clinical Convention, Dec. 4-8, 1976, Philadelphia. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

La.-Miss. O. and O. Society, April 28-May 1, 1977, Point Clear, Ala. Arthur Hays, M.D., Secy., 3017 13th St., Gulfport 39501.

STATE AND LOCAL

Mississippi Academy of Family Physicians, Annual Meeting, July 7-10, 1976, and July 6-9, 1977, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 109th Annual Session, May 2-5, 1977, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Smith, Yazoo.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Gerald A. Smith, Secy., P.O. Box 128, Sumner 38957. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. A. K. Martinolich, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Reginald P. White, Secy., East Mississippi State Hospital, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, April, June, August, October, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., Jefferson Davis Memorial Hospital, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. D. Stanley Hartness, Jr., Secy., 314 Adams St., Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Lee H. Rogers, Secy., 610 Brunson Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, October. Cherie Friedman, Secy., 1004 Jackson Ave., Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. James H. Sams, Secy., P.O. Box 1381, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, May, July, September, November. Dewey Laner, Secy., Doctors Plaza, Suite 206, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. John L. Smith, Secy., No. 1 Medical Blvd., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

When the same patient makes your office a merry-go-round of somatic complaints



Adapin® (doxepin HCl) may be what she needs

I'm so jumpy, I'm afraid of my own shadow.

I have these headaches almost everyday—I can't understand it, I never used to have them.

Doctor, is it right that I should be so constipated all the time?



Anxiety/depression could be the basis of her somatic complaints
You know the type. She's got a new symptom every visit. And there's never any physiological basis. When you see the chronic "complainer," a diagnosis of depression may be considered . . . and an Rx for Adapin.

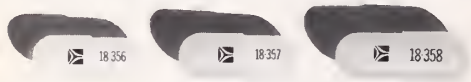
Adapin allays anxiety; improves sleep; brightens the outlook
Adapin can often help the chronic "complainers" get positively reinvolved with life. Adapin almost immediately allays symptoms of anxiety and tension. And from the earliest days it makes it easier for the patient to get to sleep—helps her stay asleep longer. And where there is underlying depression, Adapin usually begins to lift it within three or four weeks.

Please see following page for prescribing information

ADAPIN®
(Doxepin HCl)
Capsules, 10 mg, 25 mg and 50 mg

PENNWALT

ADAPIN®
(Doxepin HCl)



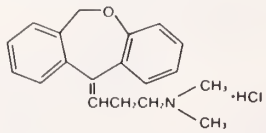
10 mg. **25 mg.** **50 mg.**

Usual optimum dosage is 75 to 150 mg. per day.

Prescribing information:

DESCRIPTION

Adapin (doxepin HCl) is an isomeric mixture of N, N-dimethyl-dibenz(b,e) oxepin- $\Delta^{11(6H)}$, γ propylamine hydrochloride.



ACTIONS

Adapin has a variety of pharmacological actions with its predominant action on the central nervous system. While its mechanism of action is not known, studies have demonstrated that it is neither a monoamine oxidase inhibitor nor a primary stimulant of the central nervous system.

INDICATIONS

In controlled clinical evaluations, **Adapin** has shown marked antianxiety and significant antidepressant effects. **Adapin** has been found to be well tolerated even in elderly patients.

Adapin is indicated for the treatment of patients with:

1. Psychoneurotic anxiety and/or depressive reactions.
2. Mixed symptoms of anxiety and depression.
3. Anxiety and/or depression associated with alcoholism.
4. Anxiety associated with organic disease.
5. Psychotic depressive disorders including involutional depression and manic-depressive reactions.

Target symptoms of psychoneurosis that respond particularly well to **Adapin** include: anxiety, tension, depression, somatic symptoms and concerns, insomnia, guilt, lack of energy, fear, apprehension and worry.

Because **Adapin** provides antidepressant as well as antianxiety effects, it is of particular value in patients in whom anxiety masks depression. Patients who have not responded to other antianxiety or antidepressant drugs may benefit from **Adapin.**

In a large series of patients systematically observed for withdrawal symptoms, none were reported—a finding which is consistent with the virtual absence of euphoria as a side effect and the lack of addictive potential characteristic of this type of chemical compound.

CONTRAINDICATIONS

Because **Adapin** has an anticholinergic effect, it is contraindicated in patients with glaucoma or a tendency toward urinary retention.

Use of **Adapin** is contraindicated in patients who have been found hypersensitive to it.

WARNINGS

Usage in Pregnancy—Adapin has not been evaluated in pregnant patients. Therefore, it should not be used during pregnancy unless, in the judgment of the physician, it is essential to the welfare of the patient.

In animal reproduction studies of **Adapin,** gross and microscopic examination of the offspring gave no evidence of drug-related teratogenic effect. Following doses of up to 25 mg./kg./day for 8 to 9 months, no changes were observed in the number of live births, litter size, or lactation. A decreased rate of conception was observed when male rats were given 25 mg./kg./day for prolonged periods—an effect which has occurred with other psychotropic drugs and has been attributed to drug effect on the central and/or autonomic nervous systems.

Usage in Children—The use of **Adapin** in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors—Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with **Adapin.** The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

PRECAUTIONS

Drowsiness may occur with **Adapin (doxepin HCl);** therefore, patients should be warned of its possible occurrence and cautioned against driving a motor vehicle or operating hazardous machinery while taking the drug.

Patients should also be cautioned that the effects of alcoholic beverages may be increased.

Since suicide is an inherent risk in depressed patients and remains a risk through the initial phases of improvement, depressed patients should be closely supervised.

Although **Adapin** has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Compounds structurally related to **Adapin** can block the effects of guanethidine and similarly acting compounds. However, at the usual clinical dosages, 75 mg. to 150 mg. per day, **Adapin** has been given concomitantly with guanethidine without blocking its antihypertensive effect. But at dosages of 300 mg. per day or higher, **Adapin** has exerted a significant blocking effect.

Adapin, like other structurally related psychotropic drugs, potentiates norepinephrine response in animals. But this effect has not been observed with **Adapin** in humans, which is in accord with the low incidence of tachycardia reported clinically.

ADVERSE REACTIONS

Anticholinergic Effects: Dry mouth, blurred vision and constipation have been reported. These are usually mild, and often subside as therapy is continued or dosage reduced.

Central Nervous System Effects: Drowsiness has been observed. It usually occurs early in the course of therapy and tends to subside as therapy continues. (See Dosage and Administration section.)

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported adverse effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects (such as increased sweating), weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

DOSAGE AND ADMINISTRATION

In most patients with mild to moderate anxiety and/or depression: 10 mg. to 25 mg. t.i.d. to start. A starting dosage of 10 mg. t.i.d. for a period of four days may reduce the initial drowsiness experienced by some patients, and may be tried in cases where drowsiness is clinically undesirable. Decrease or increase the dosage at appropriate intervals according to individual response. Usual optimum dosage is 75 mg. to 150 mg. per day.

In some patients with mild symptomatology or emotional symptoms accompanying organic disease, dosage as low as 25 mg. to 50 mg. per day has provided effective control.

In more severe anxiety and/or depression: 50 mg. t.i.d. may be required to start—if necessary, gradually increase to 300 mg. per day. Additional effectiveness is rarely obtained by exceeding 300 mg. per day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

OVERDOSAGE

Symptoms—An increase of any of the reported adverse reactions, primarily excessive sedation and anticholinergic effects such as blurred vision and dry mouth. Other effects may be: pronounced tachycardia, hypotension and extrapyramidal symptoms.

Treatment—Essentially symptomatic; supportive therapy in the case of hypotension and excessive sedation.

HOW SUPPLIED

Each capsule contains doxepin, as the hydrochloride: 10 mg. (NDC 0018-0356), 25 mg. (NDC 0018-0357) and 50 mg. (NDC 0018-0358) capsules in bottles of 100, and 1000.

Brighter days ahead for your psychosomatic complainers



PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603

Monette has generally been regarded as the outstanding Mississippi physician of his era, just as Rush has been so regarded in the nation and as Robert Dow and Joseph Montegut have been regarded in Louisiana. Monette and Rush had a significant quality in common; they were good writers. Since medicine was being learned and practiced to such a great extent on paper in those days, it was an excellent way to develop a following. Monette's medical reputation grew on the basis of his studies of yellow fever. With his yellow fever articles he carned a high reputation and had a very lucrative practice.

An illustration of how a reputation could be made on paper is afforded by the contention in the newspaper *Mississippi Free Trader* in 1841 that Monette originated quarantine to check the spread of yellow fever in 1837. This was accepted for over a century until my research in the 1960s showed that in 1817, 20 years prior to Monette's alleged accomplishment, the state's first legislature passed a stringent quarantine law directed at yellow fever in particular. In 1820 the militia was ordered into use to enforce a yellow fever quarantine.

Claims to Monette's originality in the "use of oil of turpentine as an external irritant, particularly in the treatment of typhus fever" were also probably spurious, leaving aside the feebleness of oil of turpentine as a "remedy" for typhus.

STEAM DOCTORS

Monette was the likely author of anonymous articles in the Natchez *Gazette* around 1825 aimed chiefly at the Thomsonians, practitioners of the botanic medicine system founded by Samuel Thomson. They were also popularly known as "steam doctors" because of their use of steam or vapor baths to heighten the effect of medicinal treatments, such as the specification of a vapor bath in the treatment of dropsy to make "the emetic operate more effectually." In spite of the popular nickname, however, Thomsonians based their practice principally on the use of botanic agents, as opposed to mineral agents, and only secondarily on their technique of steam baths.

A steam doctor was, Monette wrote, a "contemptible ignoramus," a "mechanic-laborer," a man "addicted to base falsehood and mean vituperation," "devoid of every principle of honor and moral rectitude." "A quack is a demagogue," Monette wrote. "Empiricism has always been the same—a compound of libels upon science and virtue, of ignorance, effrontery, and falsehood."

After hearing what Monette, a regular physician, said about steam doctors, you may well wonder how I can say to you, "You could have been a steam doctor." It is an almost universal response when reading history to identify with the admirable characters therein. Perhaps I have told you enough about Benjamin Rush and John Monette so that you do not find them admirable as practitioners. But to identify with them as regular physicians would be the usual tendency, along with disdain for the steam doctors, the homeopaths, and the hydropaths—the sectarian medical practitioners of Mississippi and the United States in the 19th century. It is helpful in gaining historical perspective to wrench yourself out of the usual and to assume the unusual.

Assume that you were Gideon Lincecum, born April 22, 1793, in Warren County, Georgia. Lincecum was eventually to practice medicine, but his medical studies were informal and spasmodic. He did not attend school or learn to read and write and spell until he was 14. At 15 Gideon began to read medical works "during odd moments" while working for a merchant in Eatonton, Georgia, 1808-1811, and then devoted full time to reading medical books for about a year.

After his family migrated to settle on the Ocmulgee River in Georgia, Gideon found time for his medical studies between hunting and fishing for a few months in 1817. Then 24 years old, he took charge of a one-room school while in the Ocmulgee settlement.

In 1818 his family migrated further westward to Tuscaloosa, Alabama. Lincecum said that by this time, "I could mix drugs and practice medicine as far as it was known in the interior of the country in those days. So I felt no alarm at the fact that my money was gone." Then 25, he had spent about four years at his irregular study of medicine, and mostly in his spare time at that. But instead of practicing medicine during the three months he was in Tuscaloosa, he worked a whipsaw and ran a billiard table.

Then he left to settle on the Tombigbee River, a few miles from the site which was to become Columbus, Mississippi. He had now left his father's household and had married. During 12 years on the Tombigbee, Lincecum engaged in farming, operated a general store (mostly an Indian trading post), and participated in civil government.

He was to reflect later, "I had, during my whole life, done all my reading in medical works, and knew all that had been published on that subject; and, had felt seriously inclined to set up shop and try to make a living in that way. But I had no medicine nor the means to procure it."

He was able in 1830 to borrow $100, and purchased "$80 worth of drugs and furniture" in Tuscumbia, Alabama. He was now 37 years old and had at last become a practicing physician. With his practice underway, he obtained credit in Mobile and added over $250 worth of drugs, furniture, and glass bottles. "It was soon widespread," he said, "that I had more medicine than all the doctors in the county, and that the man who understood the profession well enough to apply all the remedies in that shop was no ordinary doctor." In the ensuing year he made and collected over $2,000.

INDIAN HERBAL MEDICINE

But after two years of practice he concluded that regular medicines were worse than impotent; "they seemed to increase the force of the disease." As an alternative he made an arrangement with a Choctaw *alikchi chito,* or big doctor. Lincecum paid him 50 cents a day and supplied his food. The Indian spent each day collecting herb specimens while Lincecum hunted game. At night the *alikchi chito* would describe the herbs' usages and Lincecum would write it down and preserve a specimen of each herb. This went on for six weeks.

In this manner he was introduced to Indian herbal medicine. Subsequently he adopted the Thomsonian herbal system, and he added to his practice such medicaments as lobelia, cayenne, nervine, skunk cabbage, and bay berry. He believed that these agents effected speedier cures. In any event they caused no deaths.

Lincecum continued practicing both systems for two years, with Thomsonian medicines in one saddlebag and allopathic drugs in the other. He then came to the crisis in his practice to which I have alluded. One day in 1834, appalled at the deaths he was continuing to cause by extreme medication, he reined in his horse, upended one of the saddlebags, and dumped his allopathic medicines on the ground. Thereafter he confined himself to botanic practice. He was a steam doctor exclusively.

The dumping of the regular drugs had symbolic significance for American medicine. Revulsion against the methods of Benjamin Rush was causing sectarian medicine to flourish. This in turn helped pressure regular practitioners to revise their methods. As the nineteenth century unfolded, they went through a brief period of nihilism and then commenced a rational approach to therapy that was at least supportive of the health of their patients even if not crowned with real therapeutic success until the twentieth century.

Although medical science was far from adequate in combatting serious disease during Lincecum's time, there was no lack of vigor in applying measures which were known to be or thought to be efficacious. This was true of the practices of physicians and it extended to public policy as well. No less than 90 statutes on health matters were enacted during the territorial and early state period through 1848. Even prior to statehood in 1817, government in the territory had provided vaccine, imposed quarantine, operated a hospital, furnished medical care for the poor, employed public physicians, outlawed excavation of soil, and instituted food inspection.

Then in the first three decades of statehood, the licensing of physicians was written into law, charity treatment was made more extensive, health boards were established in certain locales, provisions were made concerning the sale of wholesome foods, stream pollution was proscribed, additional employment of public physicians was undertaken, health measures were enacted for prisons, and laws related to the appointment of coroners and the burying of the dead were passed. Hostility to certain practices of medical men found expression in legislation against inoculation and against the theft of corpses for dissection, and a court decision overturned the statewide medical licensing law.

THE CIVIL WAR

Against the background of legal obstacles to dissection, Civil War medical practice was a boon to Mississippi surgery because of the use to which the corpses of soldiers could be put. LeGrand James Wilson of DeSoto County gained practical training on cadavers in a "dissecting hut" which he and his colleagues set up near the battlefield. Ferdinand Eugene Daniel returned from war service to practice in Jackson and was frequently called into surgical cases elsewhere in the state as a result of his war-earned surgical skill.

Deaths of Mississippians in the Confederate Army were 2,651 from wounds and 6,807 from disease. With disease predominating in the mortality statistics, it is obvious that the professional focus of the physician in army service was little different from that of his civilian experience; and he continued to be handicapped by insufficient medical knowledge and inadequate modes of treatment. The more highly educated Civil War physicians were equipped with stethoscopes and trained in their use, but even they did not use such a simple device as a syringe, and only one physician in the entire Confederate service

is known to have possessed a clinical thermometer.

In the period 1865-1900 a growing number of additional medicaments were introduced into medical practice in Mississippi. H. H. Haralson observed that in no previous period had such a quantity of new preparations been available, but he did not equate the flood of remedies with actual progress in curing disease, which he characterized as "very slow." He praised the "let alone" system, "that intelligent forebearance in the treatment of disease."

Although some practitioners remained skeptical, others were enthusiastic about numerous agents that had been newly (and in some cases belatedly) incorporated into the practice of Mississippi physicians. Among the successes claimed were "cures of membranous croup with sulph. of copper or sub sulph. of mercury." Antifebrine as an antipyretic and antipyrine as an anodyne in the treatment of rheumatism were being prescribed. Cocaine came to be used frequently as a local anesthetic. Phenacetin, amylene hydrate, creolin, and the salicylates were employed by many physicians. Quinine was coming into even wider use in medical practice and, it was alleged, was being abused. It was a time when microbiology was becoming more influential in the practice of medicine in America and germicides and antiseptics had begun to appear in the practice of Mississippi physicians. Food therapy was also becoming popular with some practitioners.

Columbus physician J. Brownrigg, in treating a lad for tetanus, used a succession of agents including sulphate of morphine by hypodermic, chloral hydrate by enema, muriate of pilocarpine by hypodermic, tincture of belladonna and chloroform liniment externally, Celerina orally, and McMunn's elixir of opium by enema. On the eighteenth day he dismissed the case and ended all medication, and reported that two weeks later the boy "was out playing, entirely recovered." At that time infection was not suspected as the source of tetanus, as indicated in a case reported by Dr. B. F. Ward of Winona. Ward amputated a finger and laid it open, and made the comment, incredible to modern ears but indicative of the insufficiencies of the medical knowledge of even the best practitioners of his era, that "it was easy to recognize the source of the tetanic irritation in the presence of so many little sharp, jagged particles of wood, constantly pricking the nerve filaments in which they were entangled."

Twentieth century advances can be expressed succinctly from the vantage point of a physician who completed the two-year curriculum of the University of Mississippi School of Medicine in 1922 and was graduated from Tulane in 1924. In that year he would not have written a prescription that was adequate in the treatment of septic sore throat, carbuncles, blood poisoning, or other streptococcus infections, now considered trivial but then frequently deadly; neither would his practice have held a medicament that was economic and certain in pneumonia. Still in practice in 1950, at the age of, say 50, he would have seen the sulfonamides, penicillin and other antibiotics, many new hormones, and numbers of synthetics enter his practice. And at midcentury he would still have possibly 20 years of practice ahead of him, two decades in which he would prescribe antihistaminics and many other synthetics whose number had vastly increased, the greatly enlarged armamentarium of antibiotics, 40 of which became commercially available, and a greatly expanded range of biologicals.

CONCLUSION

Saying that you could have been a steam doctor serves the purpose of engendering historical detachment. It also is a means of making vivid the contrast between the manner in which you practice medicine in 1976 and the manner in which it was practiced in the earlier years of the Republic.

On the other hand I would not want this historical device to obscure the essential worth that even then adhered to medical orthodoxy, in spite of its calamitous practices. Orthodox medicine was based on serious research and systematic education. As faulty as its early results were, a foundation was being built for genuine accomplishment in the healing arts.

In Mississippi as in the rest of the country, public policy and institutional provisions were factors in medical advance. Principal acts included the state's first medical licensing law in 1819, the founding of the Mississippi State Medical Association in 1846, the establishment of the State Board of Health in 1877, the founding of the University of Mississippi two-year School of Medicine in 1903, and the expansion of the school and its move to Jackson and the Health Center in 1955.

This Bicentennial synopsis of medical practice in America, using incidents in the history of Mississippi medicine as examples, calls to mind how radically the knowledge and the methods of American physicians have advanced since 1776. The record of medical care in these two centuries bears testimony to the resilience of the human being, who has endured so much from both disease and doctor, and to the improvements in medical practice that have been made through education, persistence, and purposeful cultivation of creative genius. ★★★

Auburn University (36830)

BIBLIOGRAPHICAL NOTES

Louisiana is fortunate that John Duffy brought to publication the two-volume *Rudolph Matas History of Medicine in Louisiana.* It was published by Louisiana State University Press in 1958 and 1962 but is now out of print. There is no comparable work in Mississippi. Several accounts taken together constitute what there is of a medical history of Mississippi, and taken altogether, they are still far from satisfactory. These are:

Ewing Fox Howard, *History of the Mississippi State Medical Association,* originally published in 1910; the second edition, revised by James Grant Thompson, was published by the association in 1949.

Felix Joel Underwood and Richard Noble Whitfield, *Public Health and Medical Licensure in the State of Mississippi,* 1798-1937, published by the Board of Health in 1938 and supplemented in 1950 by a volume covering 1938-1947.

Marshall Scott Legan, "The Evolution of Public Health Services in Mississippi, 1865-1910." Unpublished Ph.D. dissertation, University of Mississippi, 1968.

Laura D. S. Harrell, "Medical Services in Mississippi, 1890-1970," in Richard Aubrey McLemore, ed., *A History of Mississippi,* University Press of Mississippi, 1973. Chapter 43, 55 pages.

My *Two Hundred Years of Pharmacy in Mississippi,* University Press of Mississippi, 1974, which has the most extensive bibliography available in the history of medicine in Mississippi, leading you to scattered articles and miscellaneous books.

The MSMA hopes to publish a revised history of the association this year but plans for it are incomplete.

FAMILY INCOME 1970-1975

The following table provides a picture of what has happened to a family's income, spending, taxes and medical care costs in the last five years.

For the Bureau of Labor Statistics' "intermediate family," medical care costs were $258 higher in 1975 than they were in 1970, a rise of 45.7 per cent. The medical care component of this table includes the costs of hospital and surgical insurance plus out-of-pocket costs for physician care, dental care and eye care, and prescription drugs. Interestingly enough, the greatest increase in costs occurred in Social Security Taxes.

The "intermediate family" spent 6.5 per cent of after tax income on medical care in 1970, 6.6 per cent of after tax income in 1975.

Intermediate Family Budgets

Source: *Bureau of Labor Statistics,* family of four assumed to have identical purchases of goods and services in 1970 and 1975.

	1970	*1975*	*$ Change*	*% Change*
Family budget				
Before taxes	$10,664	$15,318	+4,654	+43.6
After taxes	8,744	12,427	3,684	42.1
Spent for:				
Food	2,452	3,827	1,375	56.1
Housing	2,501	3,533	1,032	41.3
Transportation	912	1,279	367	40.2
Clothing, personal care	1,137	1,433	296	26.0
Other family spending	639	831	192	30.0
Charity, life ins., etc.	539	701	162	30.1
Taxes, etc.				
Social Security taxes	387	834	447	115.5
Income taxes	1,533	2,057	524	34.2
Medical care	564	822	258	45.7

Radiological Seminar CLXIII: A Simple Technique for Performing Bronchography

PAUL H. MOORE, M.D.
Pascagoula, Mississippi

As all physicians become busier, the radiologist is being called upon more and more to perform many different types of examinations. This has come about mainly for two reasons. First, the radiologist of today is more ready to attempt different procedures and second, the referring physician has realized a time savings while the patient receives equal or better studies.

Bronchography is a procedure that lends itself quite well for the radiologist to perform at his leisure. There is no need for the patient to be rushed to the Radiology Department following bronchoscopy for a so-called emergency bronchogram. Invariably the patient is half anesthetized, coughing, irritated and half of the time the tracheal tube is in the esophagus.

Bronchography is a relatively simple procedure that can give important diagnostic aid to the referring physician. The following are recognized as indications for the procedure:

A. Radiographic evidence of chest disease of unknown etiology.
B. Clinical evidence of chest disease with a normal chest radiograph.
   1. Hemoptysis
   2. Localized wheeze
   3. Previous bouts or multiple episodes of pneumonia in same area of lung
   4. Chronic cough
C. Small coin lesions.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Singing River Hospital, Pascagoula, MS.

There are only a few contraindications to performing bronchography:

1. Acute pneumonia
2. Congestive heart failure
3. Acute "asthmatic" episode
4. Massive active hemoptysis

With malpractice suits on the rampage, reaction to iodine contrast material should be mentioned but indications for the procedure should rule against this. Bronchography is a procedure that requires the full cooperation of the patient. The radiologist must be organized and prepared to bring the examination to a fast finish once the examination is initiated.

At Singing River Hospital, our group prefers to perform bronchography at our leisure when the patient and radiologist are calm and relaxed. We prefer to perform the study before the patient is bronchoscoped but it is not a disadvantage to do the procedure the day following bronchoscopy. Before the study is initiated 1/100 gr. Atropine and .5 to 1 gr. Codeine are given to the patient intramuscularly.

TABLE 1
BRONCHOGRAPHY TRAY

1. Atomizer, 4% Xylocaine
2. Cetacaine topical spray
3. Argyle suction catheter (X-ray opaque) 10 or 12 French
4. 1, 2, and 4% Xylocaine
5. Oily Dionosil
6. Catheter adapter
7. 20 cc. Disposable syringe
8. 50 cc. Disposable syringe
9. 10 cc. Disposable syringe

After arriving in the Radiology Department, the patient is informed about what to expect during the procedure. The most important point is to reassure the patient that he or she will be able to breathe with the tube in the trachea. The patient must also be instructed about breathing techniques i.e. while the catheter is being passed—shallow repetitive inspiratory phases are necessary. This keeps the vocal chords separated allowing the catheter to pass freely into the trachea.

The mucous membrane of the nose and posterior pharynx are anesthetized with Cetacaine topical anesthetic spray or 4 per cent Xylocaine in an atomizer. Following adequate anesthesia a 10 or 12 French Argyle suction catheter is utilized.

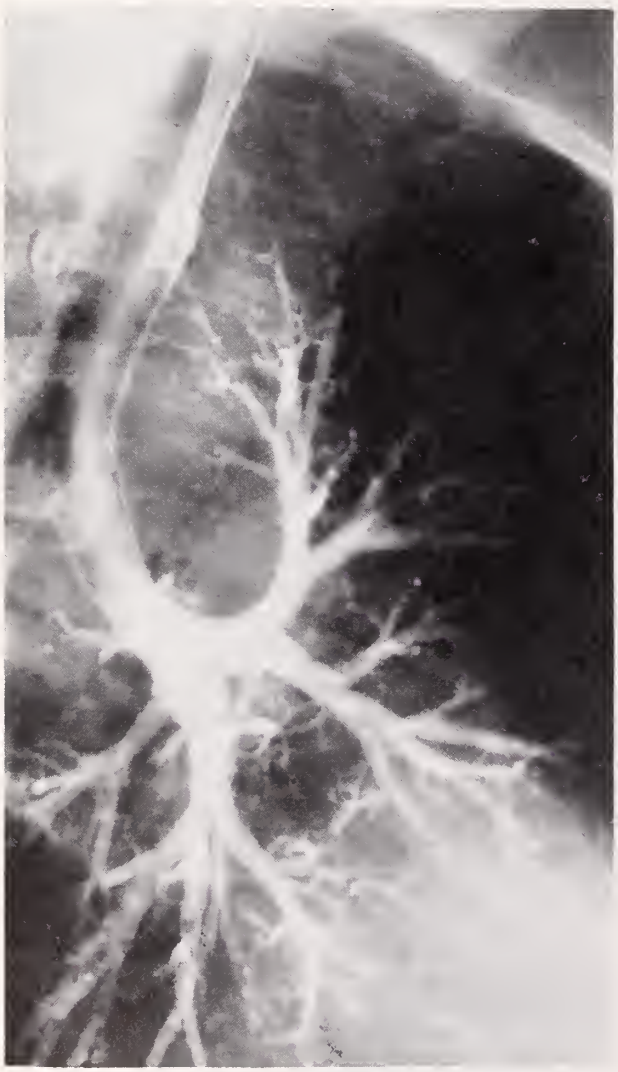


Figure 1. Left posterior oblique view of the left lung showing complete filling of normal bronchial tree.

The Argyle catheter is formed into a small J-shape and placed in ice to give it some rigidity. This aids in the passage through the nose into the nasopharynx. At this point, the patient is instructed to take shallow repetitive inspirations. During this stage the catheter is advanced slowly and in most cases slides right through into the trachea. Immediately, about 5 cc. of 1 per cent Xylocaine is forced through the tube. This helps to alleviate the episodic coughing which will be taking place. The exact location of the tube is now identified utilizing the image intensifier. The tube is placed about 1 inch about the carina and approximately 15 additional cc. of 1 per cent Xylocaine is introduced. Both lungs are anesthetized. The flow of the anesthetic is controlled with position of the patient. The patient should be instructed to fully exhale and then during the inspiratory phase,



Figure 2. Right posterior oblique view of right lung demonstrating alveolarization anterior segment right upper lobe. Complete filling of the middle and lower bronchi except posterior basilar segment.



Figure 3. Lateral view of same patient in Figure 2 showing complete filling of the middle and lower lobe segment especially posterior basilar segment. (Patient has infiltration in right lower and middle lobes.)

the Xylocaine is forced through the tube. At this point it should be difficult for the patient to cough.

Now, the tube should be positioned into the mainstem bronchus of interest. While the technologist injects oily Dionosil the radiologist should be positioning the patient and obtaining spot films of the bronchial tree. Once this is accomplished, the tube is pulled back into the trachea and the other side is studied in the same fashion. Note that time is not taken to place the catheter into the second main bronchus. Small spill in the opposite lung will not interfere as the spot films have already been obtained. At this point the examination can be terminated; however, AP and both posterior oblique views, utilizing 14 x 17 film, may be obtained.

It is very important to anesthetize both lungs even though doing only a unilateral study. This helps control coughing. It is not unusual to have some spill from one side to the other. If the lungs are not anesthetized, this will initiate coughing.

With this technique we feel that we can provide additional information to our referring physicians. There are many patients who can benefit from bronchography without having to have bronchoscopy and certainly the reverse of this statement is true. We believe that bronchography is not being used sufficiently. In our opinion radiologists are not offering this service enough, and we encourage radiologists' interest in performing the complete bronchographic examination. ★★★

Singing River Hospital (39567)

The greater the obstacle the more glory in overcoming it.
Jean Moliere

One man with courage makes a majority.
Andrew Jackson

Report of a Case of Clear-Cell Carcinoma of the Vagina

WALTER H. SIMMONS, M.D.
Jackson, Mississippi

THIS IS A REPORT of a rare, relatively new, probably iatrogenic disease of young girls.

In October 1975, E. B., a 22-year-old, married female came for routine examination and continuation of birth control pills. On detailed questioning she admitted to occasional vaginal spotting following intercourse. Menstrual periods were and always had been normal and regular. She had had one pregnancy which she lost with an early miscarriage.

Pelvic examination showed a partial stricture at the junction of the middle and upper thirds of the vagina. Above this stricture were two slightly elevated lesions—one on each side of the vagina. Pelvic examination was otherwise normal. A Pap smear was taken and was returned as a Class V. She returned two days later when each lesion was biopsied. The report was Clear-Cell Carcinoma of the vagina. Further investigation at this time revealed that this patient's mother, when 8-10 weeks pregnant, had a "threat" and was given stilbestrol 25 mgs./day for an indefinite period.

The patient was referred to The M. D. Anderson Hospital and Tumor Institute in Houston. There the diagnosis was confirmed and declared Stage II. Treatment consisted of irradiation—radium and external radiation.

At the present time she has no menstrual periods but otherwise is asymptomatic. Sexual activity is satisfactory.

This has surely been one of the most overly reported illnesses ever. An example is given from the *Miami Herald;* Wednesday, Oct. 27, 1971, P 4-A: "The Food and Drug Administration has sat for 4½ months on an appeal aimed at protecting *tens of thousands of young women* (author's italics) who risk vaginal cancer apparently caused by a drug their mothers took to prevent miscarriage." Since then there has been a steady barrage of information about this "sensational cancer."

Here are the facts: From 1945 to about 1965 diethylstilbestrol, stilbestrol or "DES," was commonly used in the treatment of threatened abortion or for the prevention of habitual abortion. About half of the female babies in utero subsequently show vaginal adenosis. Most of these adenosis lesions can be seen only by the colposcope. Of these cases of lower genital tract adenosis, a minute fraction will develop into Clear-Cell Carcinoma of the vagina or cervix.

Shortly after this disease came into prominence, *The Registry of Clear-Cell Adenocarcinoma of the Genital Tract in Young Females* was organized in Boston with Dr. Arthur Herbst as its director. Its directorship—and Dr. Herbst—were transferred to Chicago as of July 1, 1976. As of this date approximately 300 cases of Clear-Cell Carcinoma have been collected from the United States and abroad.[1] About two-thirds of these have been documented as stilbestrol-exposure in utero during early pregnancy. These range from seven years to twenty-eight years of age at the time of diagnosis. Surprisingly, only fifty per cent of asymptomatic cases showed a positive or suspicious Pap smear.

Treatment (among all centers reporting) has been radiation, surgery, and/or chemotherapy. As of Dec. 31, 1975, of 270 total cases reported (at that time) by the Registry there had been 41 deaths (15 per cent) and 22 patients in whom recurrent disease had been reported (7 per cent).

The M. D. Anderson Hospital in Houston has had 21 cases as of Aug. 11, 1976.[1] All their patients have been treated with irradiation therapy. Twenty are now living without evidence of disease. One died

Read before The Central Medical Society, Sept. 7, 1976, in Jackson, MS.
From The Simmons Clinic for Women, P.A., Jackson, MS.

a new tablet design for



Orinase®

tolbutamide, Upjohn

0.5 Gm tablets



This new design will help pharmacists, physicians, nurses, and patients identify Orinase by name and manufacturer. The number on the tablet is for identification and is not related to tablet strength.

You may wish to advise your patients that this change is taking place.

J-5255-6

The Upjohn Company, Kalamazoo, Michigan 49001 **Upjohn**

©1976 The Upjohn Company

Announcing
A Pioneering Self-Assessed
Educational Program for the
Practicing Physician

THE HYPERTENSION MEDICAL KNOWLEDGE SELF-ASSESSMENT PROGRAM

A project of The Editorial Board of
Dialogues in Hypertension
in conjunction with
The National Board of Medical Examiners

CME ACCREDITATION

As an organization accredited for Continuing Medical Education, the American Heart Association certifies this continuing medical education offer meets the criteria for 40 credit hours in Category I for the Physician's Recognition Award.

Acceptable for 40 prescribed hours by the American Academy of Family Physicians.

ENROLLMENT

You can enroll now at no cost.

For full details, see your Smith Kline &French Representative, or write: Health Learning Systems, Inc., P.O. Box 7929, E-72, Philadelphia, PA 19101.

Developed and produced by Health Learning Systems, Inc., under an educational grant from Smith Kline &French Laboratories.

of pulmonary embolus. One recurrence following radium needles had radical surgery. In only half of these (Anderson Series) patients was there a documented history of DES exposure. They feel there is good evidence that DES, in itself, is not carcinogenic but probably is teratogenic.

CONCLUSION

In conclusion it can be said again that Clear-Cell Carcinoma of the vagina is a rare disease. Incidence will be found much higher in girls born between 1945 and 1965. In examining these girls it is necessary to carefully visualize all the vaginal epithelium, do a Pap smear and a Shiller test. If any of these are suggestive, then certainly a colposcopic examination is required. ★★★

1030 North Flowood Drive (39208)

REFERENCE

1. Personal communication.

Do you know a handicapped person who needs transportation to a doctor's office? Do you know a disadvantaged child who needs tutoring? Do you know a lonely elderly person who would be reassured by a friendly telephone call? Do you know an invalid who needs a meal delivered to the home? Red Cross volunteers—The Good Neighbors—provide such services.



The President Speaking

Status of Implementation of P.L. 93-641

LYNE S. GAMBLE, M.D.
Greenville, Mississippi

AT ITS RECENT MEETING in Pascagoula, the Board of Trustees reviewed the present status of the implementation of P.L. 93-641. Dr. Howard Clark, president of the Mississippi Health Systems Agency, Inc., met with the board and reported that the Mississippi Health Systems Agency, Inc. will give top priority to developing a plan to divide Mississippi into three or more health service areas. There would be a health system agency for each area.

In accordance with the directive of the House of Delegates of the 108th annual session, the association submitted its official protest of the application of MHSA, Inc. to H.E.W. on June 25. This letter addressed some 15 points.

On July 30 MHSA, Inc. was conditionally designated by H.E.W. as the state's health systems agency upon the following conditions:

A. That the agency work with the State Health Planning and Development Agency in developing a plan for redesignating the state into more than one health service area.

B. That the agency reconsider its subarea advisory council organizational structures since it currently requires staff support that does not exist.

C. That the agency obtain review of its physician members by the appropriate medical societies or MSMA.

D. That the agency provide documentation that there is a major purchaser of health care on the board.

E. That the bylaws be amended to allow participation of provider groups not now named in the bylaws.

F. That the agency review the selection of the members of the South Mississippi subarea council to assure that the process permits proportionate representation from the Biloxi-Gulfport area.

G. That the agency provide documentation that the bylaw provision which permits the governor to appoint the president of MHSA, Inc. does not violate state law.

During the last session of the legislature, bills designating various existing agencies as the state agency were introduced. None of these bills was passed. The governor appointed his old office of Comprehensive Health Planning as the state agency by executive order. P.L. 93-641 requires that the state agency be an "agency of state government" which means that the permanent designation of the state agency still requires some action by the legislature. A state agency must be permanently designated by June of 1979 or the state will lose most of the federal health care funds.

In June Governor Finch named the members of the state health coordinating council which is the third organization authorized by

(Continued on page 309)

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XVII, NUMBER 10
OCTOBER 1976

EDITORIALS

Radiation Dangers of Mammography

The recent flurry in the news media regarding radiation dangers from mammography has caused great consternation among many patients who fear the possibility of cancer from routine mammography. Even though a later rebuttal from the American Cancer Society has quieted some of the fears, many patients still question the advisability of x-ray studies. Radiologists have noticed that the number of patients having mammographies has decreased markedly in the last few weeks and that some patients even fear x-ray examinations of the G.I. tract and chest. Where patients previously requested mammographies from their physicians, they now question the safety of the examination even when based on abnormal clinical findings.

It may be true that routine mammography in symptom-free young women is not indicated except in those with a strong familial history of cancer of the breast. After the age of 40 an annual mammography is still suggested by many physicians and is strongly advisable if there are abnormal clinical findings.

It would seem much more logical for the press to withhold such information until both sides of the story could be told. Many patients read the first article expounding the dangers of radiation and later missed or ignored the rebuttal from the American Cancer Society. Damage done by such reporting may be a long time being dispelled and can be rectified only by logical counseling by their private physician.

GEORGE H. MARTIN, M.D.
Associate Editor
Vicksburg, MS

Public Law 93-641

Public Law 93-641 Glossary:

DHEW—Department of Health, Education, and Welfare
NCPHD—National Council on Health Planning and Development
SHPDA—State Health Planning and Development Agency
SHCC—Statewide Health Coordinating Council
SHP—State Health Plan
SMFP—State Medical Facilities Plan
HSA—Health Systems Agency
HSP—Health Systems Plan
AIP—Annual Implementation Plan

Public Law 93-641 Formula:

DHEW, NCHPD, SHPDA, SHCC, SHP, SMFP, HSA, HSP, AIP = SNAFU

CHARLES L. MATHEWS

The President Speaking

(Continued)

P.L. 93-641. Of the 30 members, 6 are physicians, 4 of whom are members of MSMA. The 6 physicians are: Dr. Jim C. Barnett, Brookhaven; Dr. Albert C. Britton, Jackson; Dr. Howard C. Clark, Morton; Dr. Douglas Conner, Starkville; Dr. Mable Garner, Fayette, and Dr. Larry Mitchell, Pascagoula.

The authority of this act expires in 1977 so Congress will have to decide whether or not to extend it at that time. It has recently been announced that a three-judge panel will hear the suit being brought by the AMA, the state of North Carolina and the North Carolina Medical Association against the federal health planning law. It is thought that the designation of a three-judge panel indicates that a sub-

stantial constitutional issue is at stake.

The suit charges that the planning law violates the constitutional provisions which protect state and local governments from unwarranted interference by the federal government.

At the recent medical society executives conference on health planning sponsored by the AMA, Mr. Earl Thayer, president of AAMSE, stated "the HSA is a political animal and you need to lobby it just like you do your state legislatures. Medicine needs to be there when HSA board members are nominated, when they're elected, when they debate an issue. Medicine needs strategies and must keep the pressure on HSAs to hold them accountable. Political activity will determine our success."

This measure gives tremendous powers to the Secretary of H.E.W. I can find little evidence of the American principle of restraints in this legislation.

★★★



SIRS: It has come to our attention that some of last year's influenza vaccine may still be found in the refrigerators of some institutions, hospitals, and physicians' offices. It should not be used because it contains only A/Scotland (350 CCA units), A/Port Chalmers (350 CCA units), and B/Hong Kong (500 CCA units) influenza antigens. It contains neither A/New Jersey (the Swine influenza virus) nor A/Victoria, the two viruses which may cause influenza this coming year. Although the influenza B component in last year's vaccine is the same as that which is recommended this year by the Advisory Committee on Immunization Practices for the traditional high-risk groups, it will be available this year in a monovalent form.

All influenza A vaccines (bivalent with A/New Jersey and A/Victoria or monovalent with A/New Jersey) will be available *only* through the National Influenza Immunization Program (NIIP). These vaccines cannot be purchased from drug outlets or from the manufacturer. Influenza B vaccines *will not* be provided through the NIIP, but can be purchased through the usual commercial channels.

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health

SIRS: We have read with interest the article in the August 1976 issue of the Mississippi State Medical Association Journal. Such article was titled "Mississippi Professional Liability Premiums Rise." Reference is made in the first paragraph that the St. Paul had filed and received approval from the Mississippi Insurance Commission for rate increases amounting in some cases to 100 per cent of last year's premiums. It is our feeling that this is misleading and we feel further that clarification is indicated.

The company did file and receive approval for a rate increase. However, the actual increase from a rate standpoint is in the range of 25 per cent.

What is overlooked among many physicians is the fact that under the Claims Made rating procedure, we are just entering the second year. Even without the rate increase there would have been substantial increases in premiums brought about by the higher rates applicable to the 2nd, 3rd, 4th, and 5th year escalations under claims made rating. An illustration of this is shown as follows:

(1) For a 3-doctor partnership classified as general practitioners doing major surgery, the first year premium for 100/300 limits was $1,336.

(2) For the same insured doctors and without the rate increase, the second year premium would have been $2,128. As you can see, this is a substantial increase which is brought about by the reporting pattern of medical liability claims.

(3) For this same partnership and using the new rates, the premium is $2,707. Yes, this is a 100 per cent increase over the first year premium as outlined in Item 1 above. But the correct comparison would be to compare it to the premium shown under Item 2 which is what would have been charged if no rate increase had been involved. This comparison indicates an increase of approximately 27 per cent.

Perhaps one can say that it doesn't matter whether or not the word rate or premium is used. The average doctor is going to compare his cost this year to what he paid last year and will more than likely say that his rate has doubled. But we do not feel it is correct to say that we have increased rates 100 per cent. Substantial increases in premiums would have been involved in the absence of the recent rate change. Perhaps you could say it is a question of semantics, but it is nevertheless important for us in our attempts to secure an understanding of the claims made rating process.

I respectfully request your printing this letter in the JOURNAL, and if you are agreeable to doing this, we will be quite appreciative.

J. D. HOLLAND, Field Supervisor
The St. Paul Insurance Companies
Jackson, MS

THE LITERATURE

Book Review

Current Pediatric Diagnosis and Treatment. 4th Edition. By C. Henry Kempe, M.D.; Henry K. Silver, M.D., and Donough O'Brien, M.D. 1053 pages with illustrations. Los Altos: Lange Medical Publications, 1976. $15.00.

In its 4th edition since 1970, *Current Pediatric Diagnosis and Treatment* has become a popular textbook with medical students, residents, and practicing physicians alike. A Lange publication in paperback, the book sells for only $15.00 and at that price is quite a bargain.

Current Pediatric Diagnosis and Treatment is a textbook. It is much too large to fit into a pocket or to carry on rounds, though not as cumbersome or heavy as many hardbacked texts. As the author points out in the preface, the book was not intended to serve as a "handbook" of pediatrics.

The book is generally well done and accurate. As in all textbooks, some topics are left out and many are skimpy if one has special interest in a particular entity. However, each topic is followed by a short list of up-to-date (as late as 1975) references which provide a good starting point for further reading.

There are several unique features. Arranged in outline form with bold type to identify important subheadings, the book is readable. At the beginning of many major discussions there appears the heading "Essentials of Diagnosis" which lists the major distinguishing features of an illness—"one, two, three." There are introductory explanations and tips on "approach to the patient" intended primarily for the student. Each section contains helpful charts, graphs, and drawings when necessary to improve clarity.

The major weakness is the index. Many times there are several listings for a topic in order of appearance with nothing to indicate which is the major discussion. Cross reference is scant and listing by the specific "medical" terminology alone is definitely hard on the student.

In summary, *Current Pediatric Diagnosis and Treatment* is an adequate textbook of pediatrics which compares favorably with the higher priced hardbacked models. No doubt it will continue to gain popularity, and rightfully so.

ERWYN E. FREEMAN, JR., M.D.
Jackson, MS

PERSONALS

LOUIS A. BENOIST announces his association with J. L. HENDERSON of Natchez for the practice of orthopedic surgery at 140 Jefferson Davis Boulevard.

WILLIAM W. BRADFORD of Bay St. Louis announces his association with the Emergency Medicine Staff at Singing River Hospital in Pascagoula.

Gulfport physicians participating in the Tulane University Community Medicine Preceptorship Program are DAVID CLIPPINGER, WILLIAM J. CARR, JR., THOMAS BENEFIELD, JAMES A. SHEFFIELD, E. T. RIEMAN, JR., ROBERT A. MITCHELL, and O. D. DABBS, JR.

ROBERT L. COGGIN has opened the Children's Clinic on the Grenada County Hospital grounds for the private practice of pediatrics in Grenada.

JOHN W. COURTNEY has associated with DAVID I. CARLSON of Mississippi Anesthesia Group, P.A., for the practice of anesthesia at Hinds General Hospital, 1850 Chadwick Drive in Jackson.

The Athletic Field House at Holmes Junior College has been named the ARTHUR A. DERRICK Field House in commemoration of Dr. Derrick's long service as team physician for the college.

ROY D. DUNCAN has joined FRANCIS J. SELMAN, JR., in the practice of pediatric and adult urology at Doctor's Plaza Building on Hospital Road in Pascagoula.

JAMES O. GILMORE of Oxford has been elected chairman of the newly formed board of the Mississippi State Department of Corrections.

HENRY BROWN GOODMAN of Sharkey was honored

by Sharkey and Issaquena County citizens with an open house. He was presented a greenhouse, and an engraved plaque and a portrait of the physician were placed at Sharkey-Issaquena Hospital in Rolling Fork in his honor.

CALEB W. HERNDON announces the opening of his office for the practice of ophthalmology at 130-A North Church Street in Brookhaven.

G. H. HOLLOMAN of Canton has closed his medical practice at 134 East Peace Street.

W. BRIGGS HOPSON of Vicksburg has been appointed chairman of the American College of Surgeons' Mississippi Committee on Trauma.

WILLIAM JACKSON announces the opening of his practice of general medicine in the Magnolia Doctors Plaza, Alcorn Drive in Corinth.

JOHN R. LOVELACE of Batesville has been appointed by Gov. Cliff Finch to a 12-year term on the state college board.

Tulane University has announced that the following Pike County physicians have been named preceptors for the School of Medicine: JOHN D. MORGAN, SHELBY SMITH, WILLIAM T. MAYER, LARRY B. AYCOCK, RALPH L. BROCK, and TOM CAREY.

RICHARD A. NICHOLLS announces the relocation of his office for the practice of obstetrics and gynecology to Belair Shopping Center, Pascagoula.

MATTHEW J. PAGE of Greenville has recently been appointed to the Mississippi Medicaid Technical Advisory Committee on Physician Services. Other physicians presently serving on the technical advisory committee are JOE S. COVINGTON, Meridian, chairman; JAMES C. BASS, Laurel; LOUIS C. LEHMANN, Natchez; RALPH L. BROCK, McComb; and THOMAS W. WESSON, Tupelo. LYNE S. GAMBLE of Greenville, MSMA president, and TOM H. MITCHELL of Vicksburg, PSRO director, serve as *ex officio* members.

JOHN A. PORTER announces the opening of his office for the practice of obstetrics and gynecology at 1024 Biglane Drive in Brookhaven.

GEORGE D. PURVIS of Jackson has been elected president of the Association of Bone and Joint Surgeons.

FRED M. SANDIFER, III, announces the opening of his office for the practice of orthopedic surgery at 204 8th Street in Greenwood.

WILLIAM E. SUMNERS announces the opening of his office, The Children's Clinic, at 402 Washington Street in Booneville for the practice of pediatrics.

DAVID HENRY THORNHILL of Gloster has announced his retirement from the practice of medicine on Oct. 31, 1976.

E. W. TUCKER announces the opening of his office for the practice of obstetrics and gynecology and general medicine in the Hospital Annex Office Building in Sardis.

POSTGRADUATE CALENDAR

Oct. 4-8, 1976

FAMILY PRACTICE REVIEW

University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Family Medicine and University Medical Center Division of Continuing Health Professional Education

Coordinators:
W. Boyce White, M.D., assistant professor of family medicine, the University of Mississippi School of Medicine
Roland B. Robertson, M.D., assistant vice chancellor for VA affairs, the University of Mississippi Medical Center, and acting director, University Medical Center Division of Continuing Health Professional Education

This course is designed for the primary care physician who wishes to review new developments in family practice and prepare for the family medicine board examination. Fee: $150.00. Credit, 40 contact hours, 4.0 CEU, Category I, AMA; AAFP.

Oct. 8, 1976

EARLY DETECTION OF HEAD AND NECK CANCER: A MULTIDISCIPLINARY APPROACH

Shattuck Hall, Mississippi University for Women, Columbus

Sponsored by the University of Mississippi School of Nursing, University Medical Center Division of Continuing Health Professional Educa-

tion, and the National Cancer Institute Project for Head and Neck Cancer in cooperation with the American Cancer Society, Mississippi Division, Inc.

Coordinator:
Dale E. Clark, M.M.S., coordinator, Mississippi Head and Neck Cancer Network, the University of Mississippi Medical Center

Open to physicians, dentists, RNs, LPNs, dental hygienists, and dental auxiliaries, this session is one in a series planned to give health professionals new information about head and neck cancer, with emphasis on early detection, coordinated treatment, and total rehabilitation. Program objectives are to identify, field test, and evaluate available and new methods in a limited number of communities for the detection, diagnosis, staging, treatment, and rehabilitation of patients with head and neck cancer. Supportive data collected will be used to determine the program's practicality and acceptability prior to dissemination into the wider cancer control community programs. Other sessions are planned for Hattiesburg, Dec. 2, 1976; McComb, Feb. 17, 1977; Meridian, April 20, 1977; and Greenville, May 10, 1977. Fee: $10.00. Credit: 6 contact hours, .6 CEU, Category I, AMA; AAFP.

Oct. 11-15, 1976

ELECTROCARDIOGRAPHY INTENSIVE COURSE
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine and University Medical Center Division of Continuing Health Professional Education

Coordinator:
Thomas M. Blake, M.D., professor of medicine, the University of Mississippi School of Medicine

The week-long course will consist of a series of discussions of selected topics in electrocardiography chosen on the basis of their immediate clinical applicability. Electrocardiograms, slides, and other visual aids will be used, and participants will have the opportunity to interpret electrocardiograms, raise questions, and suggest specific topics for consideration. Interpretation of tracings will be emphasized. Fee: $125.00. Credit, 40 contact hours, 4.0 CEU, Category I, AMA, AAFP.

Oct. 25-26 (27), 1976

ONCOLOGY INTENSIVE COURSE
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Family Medicine and University Medical Center Division of Continuing Health Professional Education.

Coordinators:
Francis S. Morrison, M.D., professor of medicine and director of the division of hematology, the University of Mississippi School of Medicine
J. Tate Thigpen, M.D., assistant professor of medicine, the University of Mississippi School of Medicine

This two-day course will update primary care physicians in advances for "cure" in oncology. Participants will cover the role and principles of chemotherapy and discuss all aspects of supportive care. The optional day will offer a review of histologic sections, radiologic studies, and case discussions in connection with a review of visual oncologic material. Fee: $50.00; with optional day, $75.00. Credit: 16 contact hours, 1.6 CEU, Category I, AMA; AAFP (optional day, additional 4 contact hours, .4 CEU).

Oct. (27) 28-29, 1976

HEMATOLOGY INTENSIVE COURSE
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Family Medicine and University Medical Center Division of Continuing Health Professional Education

Coordinators:
Francis S. Morrison, M.D., professor of medicine and director of the division of hematology, the University of Mississippi School of Medicine

J. Tate Thigpen, M.D., assistant professor of medicine, the University of Mississippi School of Medicine

Participants will review recent advances in the basics of diagnosis and treatment of hematologic disorders. Modern use of blood component therapy will be discussed, and other subjects pertinent to the primary care physician will be covered. The optional day will offer a review of peripheral blood smears, slides, and special therapeutic techniques in connection with a review of visual hematologic material. Fee: $50.00; with optional

day, $75.00. Credit: 16 contact hours, 1.6 CEU, Category I, AMA; AAFP (optional day, additional 4 contact hours, .4 CEU).

Nov. 8-12, 1976

NEPHROLOGY INTENSIVE COURSE
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine, Department of Family Medicine and University Medical Center, Division of Continuing Health Professional Education with support from Mississippi Regional Medical Program.

Coordinator:
John D. Bower, M.D., professor of medicine and director of the Artificial Kidney Unit, the University of Mississippi School of Medicine

This clinically oriented one-week course will emphasize the reversible and treatable forms of kidney disease. It provides an indepth analysis of acute kidney failure management and control of the reversible features of chronic kidney disease. Participants will cover physiology, pathology, radiology, immunology, urology, transplantation, and hemodialysis in clinical nephrology. Fee: $125.00. Credit: 40 contact hours, 4.0 CEU, Category I, AMA; AAFP.

FUTURE CALENDAR

Nov. 8-12, 1976

NEPHROLOGY INTENSIVE COURSE, University Medical Center, Jackson

Dec., 1976

EARLY DETECTION OF HEAD AND NECK CANCER, Hattiesburg

Dec. 2-3, 1976

INFECTIOUS DISEASES INTENSIVE COURSE, University Medical Center, Jackson

May 2-5, 1977

Mississippi State Medical Association, Biloxi

The University of Mississippi Medical Center Division of Continuing Health Professional Education offers intensive refresher courses to meet physicians' clinical practice needs in the specialties most requested. Mississippi Regional Medical Program partially supports the series, open to all physicians. Intensive courses are eligible for AMA Physician Recognition Award Category Credit. Enrollment is limited, and applications are accepted in the order received. All correspondence about intensive and other courses should be addressed to Continuing Education, University Medical Center, 2500 North State Street, Jackson, MS 39216.

Narcotics Agents Will Aid MDs in Crime Prevention

The Mississippi Bureau of Narcotics has four agents who are graduates of the National Crime Prevention Institute at Louisville, Ky. The purpose of this training is to provide the physicians, pharmacists, and pharmaceutic wholesalers in Mississippi with professional assistance in crime prevention. This crime prevention program is aimed specifically at reducing the diversion of legitimate drugs into illegitimate channels.

These agents are available upon request for business surveys free of cost. During this survey, the businessman or professional person is shown how to improve the physical security of his premises so that the risk of burglary is reduced to a desirable probability. In the event that a larger number of requests are received than can be effectively handled by these agents, priority will be given to those locations which have the highest incidence of crime.

Request for surveys can be made by writing Agent Brenda Hyde, Mississippi Bureau of Narcotics, P.O. Box 5167, Jackson, MS 39216, or by telephoning Agent Hyde at 1-800-222-7646, or in Jackson, 354-6688.

Medicaid Surveys Pharmacy Ownership

The Mississippi Medicaid Commission is asking all pharmacies participating in the program to reveal their owners' names. The move follows closely on the heels of unsubstantiated charges on a Jackson TV station by a physician that physicians were abusing the program through their ownership of drugstores which received payments from Medicaid. The physician is not a member of his component medical society and MSMA.

The "Principles of Medical Ethics" state that it is not unethical for a physician to own or operate a pharmacy "provided there is no exploitation of the patient." In line with this the "Principles" further states that it is unethical for physicians to use prescription blanks with the name of a pharmacy printed thereon and that a patient is entitled to a copy of his or her prescription so that the prescription may be filled wherever the patient desires.

"Hands" Only May Be Decided in Court Case

By KATHY JARMON
Daily News Staff Writer

Jackson chiropractor Lewis Norville Jr., giving his second day of testimony Thursday, was cross-examined by an attorney for the Mississippi Medical Association in a Chancery Court Case which could decide whether chiropractors will be restricted in using "hands only" as opposed to sound and microwave techniques.

Chancellor George W. Haynes presided over the second day of Norville's cross-examination by attorney James K. Child Jr. in a suit, which if won by the MMA, will prevent Norville and most state chiropractors from prescribing vitamins, food supplements and using certain mechanical devices called modalities.

"Would these procedures (the prescribing of vitamins and modalities) be preparatory to or complementary to the adjustment of a normal nerve interference of the spine?" Chancellor Haynes asked Norville during the questioning.

"They are more complementary," Norville said.

A 1973 state law governing chiropractors states that the practice of chiropractic involves "the procedure preparatory to and complementary to the correction of the articulations of the vertebrae."

The MMA alleges that this does not mean chiropractors can use modalities and prescribe vitamins and food supplements.

State law says chiropractors can use X-ray machines if chiropractors are trained and tested in X-ray use, Child said.

"Isn't it correct that there are no provisions in the state law that requires a chiropractor to have training in the use of modalities, even though they are just as harmful as X-rays if improperly used?" Child asked.

"There's nothing in it that prohibits it," Norville said.

Norville testified that he has been trained in nutrition and the use of modalities through yearly weekend postgraduate work and seminars which are offered as extension courses from private corporations and chiropractic schools.

Norville said that he had only one course in modalities accredited by the Chiropractic Counsel of Education and the Department of Health, Education and Welfare.

Norville said that, under state law, he cannot accept medicaid patients. "I send in reports to medicare and my patients are reimbursed for their office fee," he said.

Norville admitted the federal government does not reimburse patients for modality treatment or for the vitamins they may purchase in his office.

"Modalities are very safe and sound if used properly," Norville said, adding that they can cause severe "contraindications," if used on patients with pacemakers or vascular disorders.

Norville said he determines if there is a danger of contraindications by consultation and examination of the patient.

"How would you locate an aneurysm in the aorta?" Chancellor Haynes asked.

"You might see it on an X-ray," Norville said, "or by the pain a patient feels when under use of one of the modalities."

Child entered into evidence photographs of labels of vitamins that Norville commonly prescribed to patients. The labels stated ingredients of those vitamins.

Norville said the vitamins were made from food supplements found in nature and were not chemicals.

Child will resume the cross examination of Norville today in the tenth day of the trial. (Reprinted from the *Jackson Daily News,* Section A—Friday, September 10, 1976.)

Editor's Note: Trial of the above suit ended on September 10 and a decision is expected the latter part of November.

Countersuit Filed Against Alleged Discrimination

MSMA member Dr. John R. Mullens of West Point has filed a countersuit asking $150,000 damages and denying a suit charging discrimination in his practice.

The countersuit which was filed in Federal Court in Aberdeen stems from a class action suit filed

against Dr. Mullens which charged him with denying medical treatment solely on the basis of race.

The class action suit was filed on behalf of two black residents of West Point by an attorney of the Mississippi Rural Legal Services who claims that his clients were denied medical treatment when they would not sit in a reception area designated for blacks.

Dr. Mullen's suit states that he does not maintain separate waiting areas for blacks and seeks $75,000 in punitive damages and $75,000 in actual and compensatory damages.

NEW MEMBERS

BUTANI, KANTA P., Tylertown. Born Kalyan, India, July 6, 1948; M.D., Sawai Man Singh Medical College Rajasthan University, Japur, India, 1969; interned St. Vincent Hospital, Worcester, MA, one year; pediatric residency, same, 1972-74; elected by South Central Medical Society.

LARKIN, WILLIAM B., JR., Bude. Born Brookhaven, MS, Dec. 23, 1943; M.D., University of Mississippi School of Medicine, Jackson, MS, 1970; interned, same, one year; elected by South Central Medical Society.

DEATHS

BILES, G. LACEY, Sumner. Born Sumner, MS, Mar. 2, 1907; M.D., Columbia University College of Physicians and Surgeons, New York, NY, 1931; interned Methodist Hospital, Brooklyn, NY, two years; died Aug. 1, 1976, age 69.

KIMBRIEL, A. C., JR., Drew. Born Drew, MS, Oct. 31, 1917; M.D., Tulane University School of Medicine, New Orleans, LA, 1944; interned Memphis Baptist Hospital, Memphis, TN, one year; died Aug. 4, 1976, age 58.

ROBINSON, THOMAS A., Whitfield. Born Mendenhall, MS, Jan. 12, 1910; M.D., University of Pennsylvania School of Medicine, Philadelphia, PA, 1948; interned Jefferson-Hillman Hospital, Birmingham, AL, one year; Residency (Psy), UMC, Jackson, MS, 1965-67; died Aug. 26, 1976, age 66.

BRIEF SUMMARY OF
PRESCRIBING INFORMATION
ANTIMINTH® (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017



eliminates Pinworms and Roundworms with a single dose

- **Single dose effectiveness against both pinworms and roundworms**—The only single-dose anthelmintic effective against pinworms *and* roundworms.
- **Nonstaining**—to oral mucosa, stomach contents, stools, clothing or linen.
- **Well tolerated**—the most frequently encountered adverse reactions are related to the gastrointestinal tract.
- **Economical**—a single prescription will treat the whole family.
- **Highly acceptable**—pleasant-tasting caramel flavor.
- **Convenient**—just 1 tsp. for every 50 lbs. of body weight. May be taken without regard to meals or time of day.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Please see prescribing information on facing page. NSN 6505-00-148-6967

Antiminth® ORAL SUSPENSION
(pyrantel pamoate) equivalent to 50mg pyrantel/ml

Constructive New Press Policy Praised

MSMA president, Dr. Lyne Gamble, has commended a Mississippi newspaper for its constructive and innovative new policy for handling news stories about civil suits. The *Mississippi Press* of Pascagola, MS, recently announced that the paper would only report civil cases after they are finalized in Circuit Court.

Gary Holland, editor of the *Mississippi Press,* announced that the new policy on civil suits was due to several factors. First, though everyone is presumed innocent until proven guilty by a court of law, the fact is that it's human nature to assume otherwise when we read an article. Secondly, anyone can file a suit; there are countless malicious and unwarranted suits. Many are thrown out; many are settled out of court and there is no public record of the settlement. Finally, two reputable doctors on the coast were recently named in a damage suit and Mr. Holland states that no doubt the coverage of "alleged" negligence can have a damaging effect on physicians who are devoting a lifetime to healing.

Dr. Gamble has urged the Mississippi press to take note of the *Mississippi Press'* new policy as announced by editor Holland.

Identification of Flu Cause Is Important

For the next several months it will be extremely important to determine what strain of influenza virus is responsible for isolated cases or outbreaks of influenza, according to the State Board of Health.

This can be determined only by appropriate serological tests or culture of the influenza virus. A small supply of screw cap tubes with the appropriate amount of transport media has been sent to health department personnel in every district. All public health nurses will know how to collect specimens and where to obtain the media.

Specimens should be collected from persons with suspect viral pneumonia or from school, industrial, family or community epidemics in the following manner:

Serologic Tests:

1. Obtain 5 to 10 cc whole blood from the patient during the acute phase of the illness. Allow it to clot and separate the serum.
2. Obtain a convalescent serum after 2-4 weeks. Serum specimens do not need to be frozen. Send both specimens, properly identified, to the State Laboratory.

Virus Isolation:

1. Swab the posterior pharynx within 48 to 72 hours after the onset of illness.
2. Place the swab in a small amount of cold tryptose phosphate with 0.5 per cent gelatin in a screw cap vial (see above). If tryptose phosphate is not available, use any other readily available transport media or even normal saline.
3. The specimen should be placed on wet ice and delivered within 3 hours to the State Laboratory. If you cannot be sure the specimen will reach the lab in 3 hours, freeze it and ship on dry ice to the State Laboratory. Dry ice mailers can be requested when needed from the State Laboratory.

Sera and swabs should be accompanied with the following information: Patient's name, age, sex, address, date of onset of illness, and major symptoms of illness (i.e., fever, headache, cough, myalgias, etc.). Questions concerning the collection of throat swabs for virus cultures or appropriate serological tests can be answered by either the State Laboratory or the SBH Bureau of Disease Control.

UMC Researcher Gets Hypertension Grant

A University of Mississippi Medical Center hypertension investigator has a $500,000 research award to conduct more studies on the baffling disease.

Dr. Robert L. Watson, UMC associate professor of preventive medicine, and 15 other scientists nationwide are engaged in a Department of Health, Education, and Welfare supported epidemiological study aimed at identifying the forerunners of hypertension.

Dr. Watson's grant from the National Heart, Lung, and Blood Institute, National Institutes of Health, will fund follow-up studies on a project which he and Dr. Herbert Langford, UMC professor of medicine, began 10 years ago.

During 1965-67, the UMC team measured blood pressures of more than 13,000 high school students in Hinds County.

In the current researeh, Dr. Watson and his team will gather information from some of the original partieipants in the study, now adults, most with families.

During the 10-year span, some of the females developed toxemia during pregnaney. From that group Dr. Watson wants to know if the mother's toxemia has affeeted the blood pressure of the ehild born after the toxemia pregnaney, and if the toxemia has made the mother's blood pressure inerease in subsequent years.

To provide more information about the relationship between environment and blood pressure, the UMC team will study sibling groups first sereened 10 years ago when most children from the same family lived in the same household.

Most of the same-family siblings live in separate households today, and the team will compare blood pressure measurements between siblings now to gauge that comparison with the blood pressure readings of the same siblings 10 years ago.

Still another study will help determine the impaet of diet on hypertension. Drs. Langford and Watson took urine samples from some of the students during 1965-67 and recorded the content of salt, potassium, calcium, and magnesium at the same time they measured blood pressure.

Dr. Watson will compare the current blood pressures of that group with the pressures taken in the mid-sixties, also measuring the intake of the same minerals. And he'll see if there is any relationship between the diets of the parents and the blood pressures of their children.

"The nationwide attack on hypertension was at first directed toward educating the public about the hazards of untreated hypertension," Dr. Watson said.

"With that program well established, the attention is now on trying to find the underlying eause or causes of the disease.

Internists Meet Oct. 29-30

Specialists in internal medieine and related medical fields from the southeastern states (Alabama, Georgia, Louisiana, Mississippi and South Carolina) will take part in a two-day scientific meeting at the Louisiana State University Medical Center, Shreveport, LA, on Oct. 29-30.

Physicians who attend the regional meeting are eligible for eredit toward the American Medieal Association's Reeognition Award in Category 1.

UMC Faculty Member Gets Fellowship

Dr. Geary Alford, assistant professor of psychiatry (psychology) at the University of Mississippi Medical Center, is recipient of a Career Medieal Teacher in Substanee Misuse Fellowship.

The grant to the Medieal Center will give Dr. Alford the opportunity for independent researeh and seminar study.

Working with the medieal school curriculum committee, primarily through the Departments of Psychiatry, Pharmaeology, and Family Medieine, Dr. Alford will assist in updating the currieulum with the newest information about drugs, their potential for abuse, and the most effective treatment.

"Physieians deal with a broad range of drug related problems," Dr. Alford said, "and we want the doetors we train to be well prepared for what they'll see in their praetiees."

Dr. Alford, one of 40 eareer teaehers in substanee misuse in the United States, will also work with state agencies as an advisor on rehabilitation, treatment, and prevention of drug abuse during the one-year grant period.



Dr. Geary Alford (left), assistant professor of psychiatry (psychology), a career teacher in substanee misuse at the University of Mississippi Medical Center, will work with the medical school curriculum committee to enhance drug abuse education for future state physicians. Dr. Edgar Draper (right) is professor and chairman of the UMC Department of Psychiatry and Human Behavior.

UMC Adds Two Faculty Members

Dr. Neil S. Whitworth and Ms. Betty Estrada Anderson have joined the faculty of the University of Mississippi School of Medicine at the Medical Center.

Vice Chancellor Dr. Norman C. Nelson announced their appointments on approval of the Board of Trustees, Institutions of Higher Learning.

Dr. Whitworth, who joined the faculty in mid-August, is a medical school assistant professor of obstetrics-gynecology and UMC assistant professor of physiology-biophysics. On the Medical Center-wide faculty, he will share teaching responsibilities for both medical and dental students.

Former assistant professor of physiology-biophysics at the University of Tennessee Center for the Health Sciences, Dr. Whitworth holds a Ph.D. degree from Rutgers University.

Ms. Anderson is an instructor in pediatrics. An administrative teaching dietitian in the Child Development Clinic at the Medical Center since 1967, she earned her M.S. degree at Memphis State University and did a dietetic internship at Walter Reed Army Medical Center. The new faculty member is a former captain in the U. S. Army Medical Specialist Corps.

Are There Too Many Medical Schools?

The nation is in danger of developing too many medical schools, the Carnegie Foundation recently warned in a report on health manpower. It said "the chief reason for new medical schools now is to achieve more adequate geographical distribution of schools." In 1970 the same group, the Carnegie Council on Policy Studies in Higher Education, had recommended expansion of medical school building. The AMA's senior vice president for scientific affairs, C. H. William Ruhe, M.D., commenting on the report, said the AMA has "never taken the position there are too many medical schools, and we disagree with (the report's) proposal to determine exact numbers and locations of schools. . . . We don't see any evidence of an excess of physicians. Although we do acknowledge a differential rate of growth, we aren't ready to sound the alarm."

The Carnegie Council also warned that "there is a critical danger that concern over geographic maldistribution of health manpower and overspecialization in medicine could lead to excessive and unwieldy federal controls." It also said "the time has come to cease relying on foreign medical graduates to meet the need for physicians in the United States." Noting the rapid increase of U. S. medical graduates, the council said it "favors discontinuing preferential immigration status for foreign medical graduates and requiring them to meet the same standards American medical graduates meet before entering residency training or medical practice."

UMC Lab Gets Bac Tec System



Profits from Spring Fling and a gourmet food sale, both sponsored by the University of Mississippi Medical Center Auxiliaries Board, governing body of the combined Medical Center auxiliaries, netted $4,300 to buy a bacterial detection system for the UMC clinical sciences laboratory. Dr. Warren Bell (left), professor and chairman of the Department of Clinical Laboratory Sciences, accepts the check from Spring Fling co-chairman Mrs. James Suess. William T. Newell is hospital director, and other Spring Fling co-chairmen are Mrs. Warren Bell (right) and Mrs. Robert Sloan.

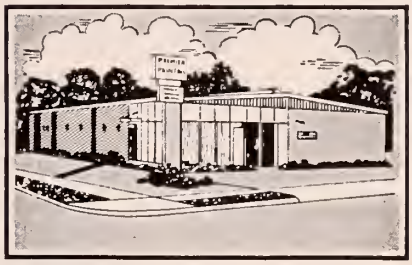
CLASSIFIED

TAX DEDUCTIBLE VACATIONS FOR MEDICAL PROFESSIONALS. Over 500 listings of national/international meetings in the medical sciences for 1977. Send a $10 check or money order payable to Professional Calendars, P.O. Box 40083, Washington, D.C. 20016.

JOIN MPAC TODAY

PRINTING — OFFICE SUPPLIES

EQUIPMENT — FURNITURE



Premier Printing Company

2485 West Capitol Jackson, Mississippi

Phone 352-4091

Index to Advertisers

Burroughs Wellcome Co. 8

Canton Exchange Bank 6
Coca-Cola 6

Family Practice Physicians 10
Fidelity Bank 10

Hill Crest Hospital 7
Humana, Inc. 14
Hyrex-Key Pharmaceuticals 4

Eli Lilly and Co. front cover

Mallinckrodt, Inc. 6A
Mead Johnson Laboratories 12

Pennwalt Prescription Products 298B, 298C, 298D
Pharmaceutical Manufacturers Assoc. 14B, 15
Premier Printing Co. 19
Professional Calendars 19

A. H. Robins Co. 10A, 10B, 11
Roche Laboratories second cover, 3, third and fourth covers
Roerig and Co. 14A, 316, 317

Smith Kline and French 306B

The Upjohn Co. 306A

Warner Chilcott Laboratories 16, 17

Thomas Yates and Co. 18

IN CONCLUSION

Senator Edward Kennedy (D.-Mass.) challenged the pharmaceutical industry to establish a vehicle for the collection of "national drug use data," in his keynote address at the PMA annual meeting in West Virginia. Citing collection of drug data as "essential to measure not only the risks, but also the benefits of actual drug use," he said that this emerged as the "number one priority" from his early health subcommittee hearings on the pharmaceutical industry. He suggested that PMA create an independent nonprofit corporation for data collection.

Malpractice is not only a problem for physicians. At a recent meeting of the National Association of Retail Druggists, two legal experts warned pharmacists that they also face an increased risk of being sued for malpractice. Sidney Waller, NARD's general counsel, placed part of the blame on our suit-prone society. Drug substitution laws also have added to the profession's potential liability for negligence if pharmacists selected drugs that were not safe, or if patients incurred harm as a result of the medication.

For the first time since 1967, U.S. deaths from major cardiovascular diseases have dipped below one million, according to HEW's National Center for Health Statistics. Their provisional data indicate that, during 1975, the number of U.S. deaths from major CVD was 979,180. The 1975 statistics also showed that the U.S. mortality rate from all causes of death combined was the lowest in our history and has declined by 24 per cent since 1950, with reductions in CVD mortality rates accounting for about 65 per cent of the total.

A Hypertension Medical Knowledge Self-Assessment Program will be introduced to physicians in January. The program is being developed by the Editorial Board of Dialogues in Hypertension in conjunction with the National Board of Medical Examiners by Health Learning Systems, Inc., in cooperation with National High Blood Pressure Education Program, American Heart Association and National Kidney Foundation. Beginning in January with a confidential pre-course evaluation, the program will continue through early 1978 and carries 40 prescribed AAFP hours.

A child is more likely to have an accident if he/she has recently undergone a period of emotional stress, according to Washington researchers in Pediatrics who investigated the phenomenon of "accident-prone" children and studied 103 seventh grade boys. No relationship was discovered between high risk-taking children and the number of reported accidents, but a child's score on a life-change questionnaire did correlate with his likelihood of sustaining an injury. Subjects having high life-change scores had significantly more accidents.

THE ANXIETY-SPECIFIC.

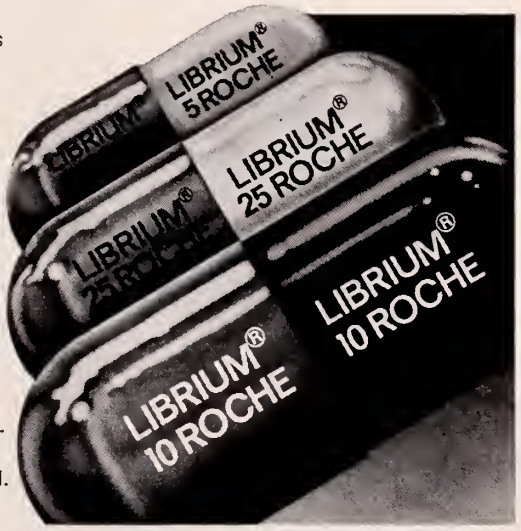
- a predictable pattern of patient response
- seldom associated with serious side effects, in proper dosage
- rarely interferes with mental acuity
- used concomitantly with many primary medications
- three dosage strengths meet most patient needs

LIBRIUM® ℞

chlordiazepoxide HCl/Roche

5mg, 10mg, 25mg capsules

Libritabs® (chlordiazepoxide) available in 5 mg, 10 mg and 25 mg tablets.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, New Jersey 07110

Please see following page.

THE ANXIETY-SPECIFIC

Since its discovery in the research laboratories at Roche, Librium has been the object of ongoing pharmacologic and clinical investigation.

The published record on Librium is enormous. So large, in fact, we put it into a computer literature retrieval system to make it more accessible in answering your inquiries.*

It's a record that reveals a consistent pattern of patient response. A highly favorable benefits-to-risk ratio. And minimal interference with many primary medications.

Doing one thing well. Basically, that's what Librium is all about.

LIBRIUM® IV
chlordiazepoxide HCl/Roche

2EAST 103RD ST
NEW YORK N.Y.
10029

LIBRARY
OCT 21 1976
NEW YORK ACADEMY OF MEDICINE



ROCHE

*If you have a question about Librium or any other Roche product, write to Professional Services, Roche Laboratories, Nutley, New Jersey 07110.

Please see preceding page for a summary of product information.

BALCON

AMERICAN REVOLUTION BICENTENNIAL 1776-1976

JOURNAL OF THE Mississippi STATE MEDICAL ASSOCIATION

NOVEMBER 1976

From Lilly/Dista Research

NALFON®
fenoprofen calcium
300-mg.* Pulvules®

DISTA
Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

Additional information available to the profession on request.

*Present as 345.9 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. fenoprofen.

600120

This Month . . . Idiopathic Scoliosis, Intestinal Obstruction, Bleeding Diverticulosis of the Colon

M.S.M.A.

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

HOW MUCH DO YOU MAKE?

That's how much you could lose . . . and more . . . if an accident or illness totally disabled you and you were unable to continue your practice. Not only would you lose your personal income, but the cost of maintaining your office would also continue. YOU COULD LOSE TWICE AS MUCH as another person might because you have two sets of expenses. To help you fight this possibility, the Mississippi State Medical Association makes available to members two excellent programs that help cover both ends of your expense picture: the INCOME PROTECTION PROGRAM for personal expenses, and the tax-deductible PROFESSIONAL OVERHEAD EXPENSE PROTECTION PROGRAM for your business expenses.

■ TO HELP PAY YOUR PERSONAL EXPENSES, THERE'S MSMA'S INCOME PROTECTION PROGRAM

When you're not practicing, your income stops. Just paying your everyday expenses could run into a great deal of money, draining your savings, especially if your income were cut off indefinitely. The MSMA INCOME PROTECTION PROGRAM can pay as much as $2,000 a month income replacement benefits payable for up to LIFETIME for accident-caused disabilities, TO AGE 65 for disabilities resulting from illness. And, you choose when you want the benefits to begin — either the 31st or the 91st day of disability — to give you the coverage that best fits your own individual needs.

■ TO HELP PAY BUSINESS COSTS, PROFESSIONAL OVERHEAD EXPENSE PROTECTION'S FOR YOU

Whether you're there or not, it costs the same amount of money each month to keep your office open. But, with no money coming in, it could really put you in a serious financial position. You need the businessman's insurance with your practice in mind — the MSMA PROFESSIONAL OVERHEAD EXPENSE PROTECTION PROGRAM. It works for you when you can't. It'll pay 100% of your covered fixed overhead costs — even up to $3,500 a month, the maximum amount available. And, the benefits are available for as long as 18 months. Premiums may be deducted as a direct business expense, too.

WANT TO KNOW MORE? WRITE TODAY!

Protect yourself and your family. Protect your investment in your business. Find out more about these exceptional MSMA Programs. Write to THOMAS YATES & CO., P. O. Box 1054, Bankers Trust Plaza Building, Jackson, Mississippi 39205 for brochures describing the benefits, features, limitations, exclusions and premiums of each Plan.

These Plans Are Offered By

THOMAS YATES & CO.
P.O. Box 1054
Bankers Trust Plaza Building
Jackson, Mississippi 39205

THOMAS YATES & CO. has been awarded the seal of the American Institute of Professional Association Group Insurance Administrators — "In recognition of professional excellence in serving clients with an integrity worthy of the highest trust." Membership in the Institute is by invitation only.

THESE PLANS ARE MSMA SPONSORED

The INCOME PROTECTION PROGRAM and the PROFESSIONAL OVERHEAD EXPENSE PROTECTION PROGRAM are officially sponsored and endorsed by the Mississippi State Medical Association exclusively for its members.

Also sponsored by the MSMA are the HOSPITAL MONEY PLAN, MAJOR MEDICAL PLAN, EXCESS MAJOR MEDICAL PLAN, and TERM LIFE INSURANCE. Brochures for these programs are also available.

Underwritten By

CONTINENTAL CASUALTY Co.
Association Group Division
CNA Plaza • Chicago, Illinois 60685

Volume XVII
Number 11
November 1976



JOURNAL of the Mississippi
STATE MEDICAL ASSOCIATION

• EDITOR
W. Moncure Dabney, M.D.
• ASSOCIATE EDITORS
George H. Martin, M.D.
Myron W. Lockey, M.D.
• MANAGING EDITOR
Nola Gibson
• PUBLICATIONS COMMITTEE
Lawrence W. Long, M.D.
Chairman
Robert R. McGee, M.D.
T. A. Baines, M.D.
and the editors
• THE ASSOCIATION
Lyne S. Gamble, M.D.
President
James O. Gilmore, M.D.
President-Elect
J. Elmer Nix, M.D.
Secretary-Treasurer
C. D. Taylor, Jr., M.D.
Speaker
R. Faser Triplett, M.D.
Vice Speaker
Charles L. Mathews
Executive Secretary
H. Cody Harrell
Assistant Executive Secretary and Comptroller
William F. Roberts
Assistant Executive Secretary and Legal Counsel

The Journal of the Mississippi State Medical Association is owned and published monthly by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, $15.00 per annum; $2 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

CONTENTS

ORIGINAL SCIENTIFIC PAPERS

Idiopathic Scoliosis **321** Buford Yerger, Jr., M.D., Jackson, MS

Problems in Abdominal Surgery VI. Intestinal Obstruction From Peritoneal Carcinomatosis **325** William O. Barnett, M.D., Jackson, MS

SPECIAL ARTICLES

Radiological Seminar CLXIV: Angiographic Localization of Bleeding Diverticulosis of the Colon: A Case Report **328** Jerry T. Russell, M.D., and Charles A. Marascalco, M.D., Vicksburg, MS

MSMA: You're Ten Years Older Than You Think! **330** Laura D. S. Sturdivant, Jackson, MS

EDITORIALS

Physicians Beware! Medicine Is Being Assaulted **335** Myron W. Lockey, M.D., Jackson, MS

Medicaid Costs and Controversy **336** Charles L. Mathews

THIS MONTH

The President Speaking **334** CME and the "Good Physician"

Medical Organization **341** The Mississippi Public Health Association Holds 39th Annual Meeting in Jackson

Copyright 1976, Mississippi State Medical Association

Physician-Owned Insurance Grows

According to a survey by the National Center for Health Services Research of Rockville, MD, physician-owned companies are operating in Arizona, Florida, Illinois, Maryland, Michigan, New Mexico, New York, North Carolina, and Tennessee. Three companies are operating in the Alameda-Contra Costa, Santa Clara, and Los Angeles areas in California, while the California Medical Association is in the process of establishing a statewide insurance company. Other states where physician-owned companies are in the start-up stages are Alabama, Massachusetts, Ohio, and Pennsylvania.

In Maryland, the Medical Mutual Liability Insurance Society of Maryland has been in operation since June 2, 1975, having been created under a special act of the state legislature. John Sargeant, C.A.E., executive director of the Medical and Chirurgical Faculty of Maryland, reports that to date the company has not had to pay any awards. The company offers basic $100,000/$300,000 occurrence coverage to its insureds, which number 3,200 out of a total doctor population of nearly 5,100. Sargeant stated that the company's rates "compare favorably" with those of the state's sole remaining carrier, Inland Mutual Fire and Marine of Philadelphia, which is scheduled to withdraw from the state as of Dec. 31, 1976.

New Mexico Physicians Mutual, which began operations on Mar. 1, 1976, insures approximately 95 per cent of the state's eligible physicians, said Mr. Don Letherer, its executive vice-president. He stated that as of Sept. 18, NMPM began offering coverage to hospitals and osteopaths, although some hospitals, clinics and medical schools will be retaining their private-carrier coverage.

In Michigan, the Michigan Physicians Mutual Liability Insurance Company currently insures about 15 per cent of the eligible doctors, offering $100,000/$300,000 occurrence coverage. Its rates are "right in the middle" between other carriers, a spokesman said, noting that the Medical Protective Company's rates are presently the lowest.

On the national level both the American Hospital Association and the American Medical Association have taken steps to establish reinsurance for hospital and doctor-owned insurance companies.

Is there a tablet containing *only* an expectorant and *only* Glyceryl Guaiacolate? YES!

1. Patient acceptable tablet dose.
2. Single entity expectorant.
3. Measured tablet dose.
4. Sugar-free tablet.

An identifiable white, scored tablet which significantly stimulates the secretion of respiratory tract fluid.

HYTUSS TABS

(GLYCERYL GUAIACOLATE 100mg.)





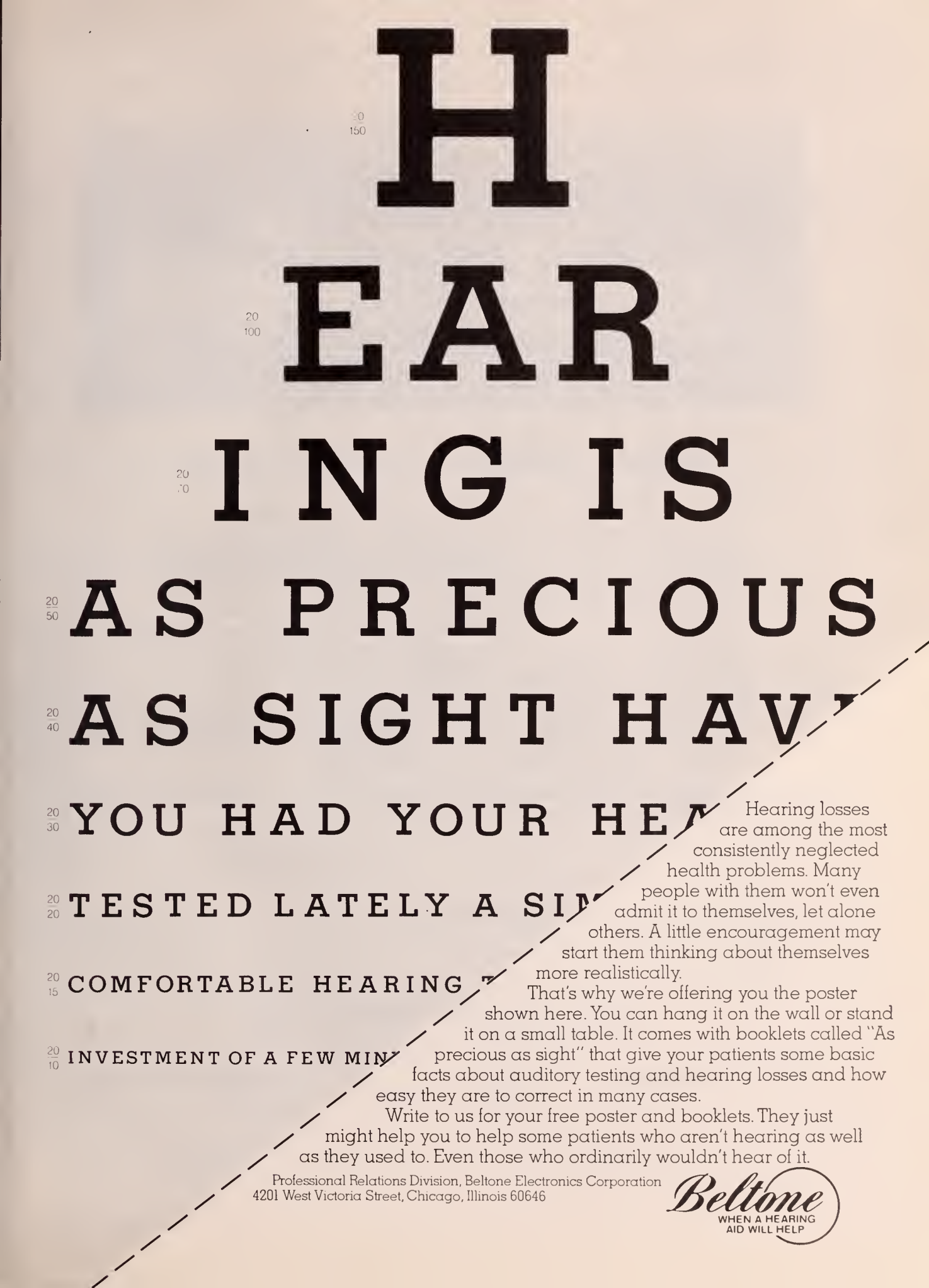
Composition: Each sugar-free compressed tablet contains glyceryl guaiacolate 100mg. **Action and Use:** This preparation utilizes the effective expectorant action of glyceryl guaiacolate which significantly stimulates the secretion of respiratory tract fluid. The increased flow of less viscid fluid favors expectoration and has a demulcent effect on the tracheobronchial mucosa. The primary usefulness of Hytuss Tabs is to promote the change from a dry, unproductive cough to a productive cough. Hytuss is therefore useful in treating coughs due to the common cold, bronchitis, laryngitis, tracheitis, pharyngitis, influenza and the measles. The expectorant action of Hytuss may also provide symptomatic relief in some chronic respiratory disorders when the patient experiences spasms of dry nonproductive coughing. **Precautions:** Extremely large amounts may cause nausea and vomiting. **Administration and Dosage:** *Adults*—1 tablet four times daily. *Children*—6 to 12 years of age; ½ tablet 3 or 4 times daily. HOW SUPPLIED: White, scored, sugar-free, tablet in bottles of 100 - 1,000 - 5,000. **Product Identification Mark:** Hy. **Literature Available:** On request.

Available through all drug wholesalers.

Hyrex

HYREX COMPANY

832 South Cooper
Memphis, Tenn. 38104



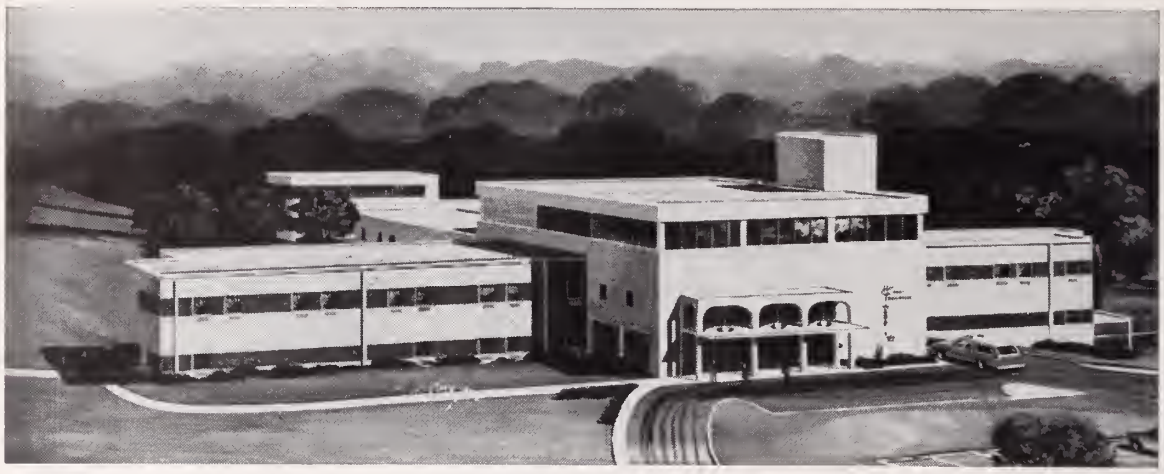
Hearing losses are among the most consistently neglected health problems. Many people with them won't even admit it to themselves, let alone others. A little encouragement may start them thinking about themselves more realistically.

That's why we're offering you the poster shown here. You can hang it on the wall or stand it on a small table. It comes with booklets called "As precious as sight" that give your patients some basic facts about auditory testing and hearing losses and how easy they are to correct in many cases.

Write to us for your free poster and booklets. They just might help you to help some patients who aren't hearing as well as they used to. Even those who ordinarily wouldn't hear of it.

Professional Relations Division, Beltone Electronics Corporation
4201 West Victoria Street, Chicago, Illinois 60646

Beltone
WHEN A HEARING AID WILL HELP



HILL CREST HOSPITAL

For Intensive Treatment of Psychiatric Disorders

This 101-bed non-governmental psychiatric hospital provides modern facilities for diagnosis and treatment of patients with all degrees of illness, including those who show severely disturbed behavior. Alcoholic and drug abuse patients are also accepted.

In addition to care by psychiatrists and by consultants in all medical specialties, the treatment program includes occupational, recreational, and physical therapy, social services, and tutoring. Emphasis is on short-term, intensive treatment of voluntary patients.

Hill Crest is a member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Alabama Hospital Association, Birmingham Regional Hospital Council.

Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved. Blue Cross Participating Hospital.

ADMINISTRATOR: Robert V. Sanders

HILL CREST HOSPITAL

HILL CREST FOUNDATION, INC.

6869 Fifth Avenue South **Birmingham, Alabama 35212**

PHONE: 205-836-7201

NEWSLETTER

November 1976

Dear Doctor:

The Mississippi State Medical Association's computerized membership billing statement for 1977 dues will include a $15.00 assessment to fund a statewide media campaign to educate the public about the professional liability insurance crisis and the need for corrective legislation in this regard. The assessment was authorized by the MSMA House of Delegates at the 1976 annual session.

> MSMA's membership reached a new all time high in 1976. A total of 1562 Mississippi physicians are now members of the association, an increase of almost 50 members over 1975 and the largest increase in recent years, according to the MSMA Membership Office.

As of the early part of September 1976, 111 hospitals of the 116 eligible have become participants in the Mississippi PSRO program. Of the 111 participating hospitals, 76 are on binding review and 35 in the implementation mode. The Mississippi Foundation for Medical Care, Inc., responsible for PSRO in MS, has conducted nine audit workshops since August 1975.

The Secretary of Health, Education and Welfare has announced that the inpatient hospital deductible under Part A of Medicare will be increased from $104 to $124 for benefit periods beginning in 1977. Notice of the $124 deductible and related coinsurance amounts has been published in the Federal Register, according to Thomas M. Tierney, director, Bureau of Health Insurance, HEW.

A Maryland court may have set the record for the stiffest sentence in a Medicaid fraud trial. It sentenced a dentist to four years in the Maryland penitentiary September 15 for defrauding the state's Medicaid program. The dentist was found guilty on 12 of 74 counts of obtaining money under false pretenses under the Medicaid program, according to the Health Services Information sheet.

The week of November 21-27, 1976, has been designated as National Family Week by President Gerald Ford. Purpose of the week is to promote recognition of and appreciation for the American family as the foundation of our free society and to lay before each family the continuing challenge to save and preserve freedom, dignity, honor, and mutual trust among the people.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

FAMILY PHYSICIANS

OAKDALE, LOUISIANA needs three Family Physicians immediately. Oakdale, population 7,500, business trade 25,000, is located in Central Louisiana near Alexandria. It is a thriving community with a diversified economic base. A new, modern equipped, 61-bed, JCAH accredited hospital completed in 1973.

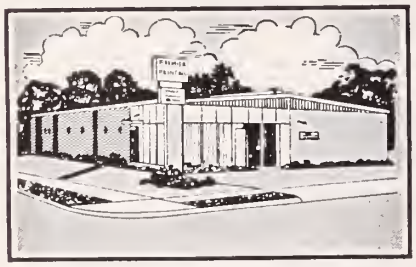
FINANCIAL ASSISTANCE AND OFFICE SPACE AVAILABLE

For detailed information call collect or send Curriculum Vita, Administrator, Oakdale General Hospital, 130 North Hospital Drive, Oakdale, Louisiana 71463 (318) 335-3700.

HUMANA, INC.
THE HOSPITAL COMPANY
P.O. BOX 1438
LOUISVILLE, KY 40201

PRINTING — OFFICE SUPPLIES

EQUIPMENT — FURNITURE



Premier Printing Company

2485 West Capitol Jackson, Mississippi

Phone 352-4091

Group Practice Grows

While a substantial portion of the nation's health care is still delivered by the solo practitioner, medical group practice continues to show significant growth in the 1970s.

This is a major finding of the 1975/76 edition of the American Medical Association's *Profile of Medical Practice*. The book is the fifth in a series which provides reference data on the practice of medicine in the U.S.

Today, there are 8,483 medical groups in the United States, whose 66,842 physicians represent 23.5 per cent of the active nonfederal physician population, the AMA studies find. Medical groups are also increasing in size as well as in number. If present trends continue, it is likely that the solo, fee-for-service practitioner will continue to decline in importance while group practice becomes more prevalent. The small-scale, single-specialty group of three to five physicians may well become the predominant choice of young physicians.

Other highlights of *Profile of Medical Practice* include:

—Municipal hospitals are devoting more resources to outpatient and emergency care and less to inpatients in the 1970s, and these trends most likely will continue into the 1980s. Many patients will continue to visit emergency departments at hospitals for non-emergency health conditions.

—A review of the literature suggests that health care researchers generally agree that allied health workers can increase the physician's productivity. There appears to be important potential for delegation of many routine tasks by the physician.

—Economic controls, in effect from August 1971 to April 1974, appear to have had an important impact on physicians' incomes. For most specialists, evidence indicates that increases in practice expenses exceeded the rate of increases in fees, and that this has had a dampening effect on the rate of change in net incomes. Evidence also indicates that the rate of increase in net incomes may be returning to precontrol levels.

—There is wide geographic variation in physician's fees, ranging from $6.49 for follow-up office visit in communities with less than 10,000 persons to $17.01 for areas with populations over five million. Much of this variation is due to the specialty composition of the area.

Cold/Allergy and Cough Country



Rynatan® Country

RYNATAN, for symptomatic relief of colds and allergic rhinitis. Convenient b.i.d. tablet and liquid dosage.

Rynatuss® Country

RYNATUSS, for symptomatic relief of coughs due to colds and in acute and chronic bronchitis. Convenient b.i.d. tablet and liquid dosage.

Mallinckrodt Pharmaceuticals *Linking chemistry to medicine®*

Mallinckrodt, Inc. St. Louis, Mo. 63147

RYNATAN®: Each tablet contains Phenylephrine Tannate, 25 mg.; Chlorpheniramine Tannate, 8 mg.; Pyrilamine Tannate, 25 mg.

Each 5 ml. (1 teaspoonful) RYNATAN® PEDIATRIC SUSPENSION contains: Phenylephrine Tannate, 5 mg.; Chlorpheniramine Tannate, 2 mg.; Pyrilamine Tannate, 12.5 mg. CONVENIENT B.I.D. DOSAGE for convenience and economy.

INDICATIONS: RYNATAN provides symptomatic relief of the coryza and nasal congestion associated with the common cold; other upper respiratory infections and allergic rhinitis. In sinusitis, drainage from the affected sinuses may be improved.

CONTRAINDICATIONS: RYNATAN is contraindicated in those patients who are sensitive to sympathomimetic drugs.

PRECAUTIONS: Use with caution in patients with hypertension, hyperthyroidism, diabetes or coronary artery disease; warn of possible drowsiness in patients who may operate vehicles or machinery.

ADVERSE REACTIONS: Drowsiness and dryness of the mouth are occasionally associated with antihistamine therapy in some individuals.

DOSAGE AND ADMINISTRATION: RYNATAN TABLETS: 1 or 2 tablets every 12 hours.

RYNATAN PEDIATRIC SUSPENSION: For children over six years of age, 5 to 10 ml. (1 to 2 teaspoonfuls) every 12 hours; for children two to six years of age, 2.5 to 5 ml. (½ to 1 teaspoonful) every 12 hours; for children under two years of age, 1.7 ml. (⅓ teaspoonful) every 12 hours.

CAUTION: Federal (U.S.A.) law prohibits dispensing without prescription.

RYNATUSS®: Each tablet contains Carbetapentane Tannate, 60 mg.; Chlorpheniramine Tannate, 5 mg.; Ephedrine Tannate, 10 mg.; Phenylephrine Tannate, 10 mg.

Each 5 ml. (1 teaspoonful) RYNATUSS® PEDIATRIC SUSPENSION contains: Carbetapentane Tannate, 30 mg.; Chlorpheniramine Tannate, 4 mg.; Ephedrine Tannate, 5 mg.; Phenylephrine Tannate, 5 mg. CONVENIENT B.I.D. DOSAGE for convenience and economy.

INDICATIONS: In the treatment of coughs due to the common cold, asthma, and in acute and chronic bronchitis.

CONTRAINDICATIONS: RYNATUSS is contraindicated in those patients who are sensitive to sympathomimetic drugs.

PRECAUTIONS: Use with caution in patients with hypertension, hyperthyroidism, diabetes or coronary artery disease; warn of possible drowsiness in patients who may operate vehicles or machinery.

ADVERSE REACTIONS: Drowsiness and dryness of the mouth are occasionally associated with antihistamine therapy in some individuals.

DOSAGE AND ADMINISTRATION: RYNATUSS TABLETS: Adults—1 to 2 tablets every 12 hours.

RYNATUSS PEDIATRIC SUSPENSION: For children over six years of age, 5 to 10 ml. (1 to 2 teaspoonfuls) every 12 hours; for children two to six years of age, 2.5 to 5 ml. (½ to 1 teaspoonful) every 12 hours; for children under two years of age, 1.7 ml. (⅓ teaspoonful) every 12 hours.

CAUTION: Federal (U.S.A.) law prohibits dispensing without prescription.

The above represents a brief summary. See package inserts for full prescribing information.

Counsel to Authors

THE JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, Miss. 39216, in original and at least one duplicate copy. They must be typewritten double spaced on 8½ by 11-inch white bond paper with a standard typewriter.

The author is responsible for all statements made in his work, including changes made by the manuscript editor. Manuscripts are received with the understanding that they are not under simultaneous consideration by any other publication and have not been previously published. All manuscripts will be acknowledged, and while those rejected are generally returned to the author, the JOURNAL is not responsible in event of loss. Manuscripts accepted for publication become the property of the JOURNAL and are copyrighted by the association when published. They may not be published elsewhere without written release and permission from both the JOURNAL and the author.

All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus,* volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made after proof sheets are received by the JOURNAL.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for illustration engravings not exceeding four column inches per printed page.

Illustrations must be numbered and cited in the text. Legends, not exceeding 40 words and preferably shorter, must accompany each illustration, typed double spaced on separate sheets. The following information should appear on a gummed label affixed to the back of each illustration: Figure number, manuscript title, author's name, and arrow indicating top of the illustration.

In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

A thesis summary of 75 to 100 words must accompany each manuscript separately from the text.

Reprints may be obtained at cost plus shipping charges from the association and should be ordered prior to publication. The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. —*The Editors.*

ASC Withdraws Oversupply Report

The American College of Surgeons has withdrawn a report it cosponsored last year which stated the country would be flooded with surgeons in the near future and that cutbacks in training programs should be initiated. ACS says now that the figures used in the report are unreliable.

There is no impending overproduction of surgeons, ACS staffer James Haug said in the organization's monthly publication. The fact is "there is already a diminished production of surgeons, and if some form of national health insurance is enacted, the demand for surgical services will rise, not fall," he said.

War on Poverty Criticized

In a recent editorial critical of Senator Moss "Shuffling around urban ghettos to investigate Medicaid fraud" the *Wall Street Journal* makes the point that helping the poor, at taxpayers' expense, has become a very large industry.

"The senator's act, for all its imaginativeness, had two flaws: It was intended to imply that the Ford administration and crooked doctors are to blame for what in fact has been a broad failure of government, and, in particular, Congress."

"The fundamental flaw is fairly simple. The War on Poverty was not designed to give money to the poor but to give money to people who provide services to the poor. As a political idea this was ingenious. It attracted support to President Johnson from powerful lobbies, such as organized medicine, the building trades unions, contractors and public employees. Guided by a president who understood congressional politics as few presidents have, program after program sailed through—to build housing for the poor, to treat the illnesses of the poor, to provide nursing homes for the poor, to train the poor, etc., etc."

". . . Most of the nation's poor could have been made relatively rich if the federal government had simply handed them all the money it has passed out to 'vendors' of services to the poor.

"Unfortunately, the momentum of congressional politics pushes the opposite way, toward federal handouts for even more medical services, for example. Those lobbyists of the 1960s have plans to turn larger expenditures of tax money to their advantage. 'National health' is the next big hobby horse and is no doubt one that the Moss exercise was intended to further."

helping you change things for the better

Canton Exchange Bank

A FULL SERVICE BANK

"Your Account Handled in Strict Confidence"

Each depositor insured to $40,000

Branch Offices
Canton East Branch
Bank Of Madison
Bank Of Ridgeland

FDIC

"Our 96th Year Of Continuous Service"

Federal Deposit Insurance Corporation

it's the real thing



70-37

Mississippi Council of Coca-Cola Bottlers

consider the effect on coexisting diabetes when you prescribe a vasodilator*



(POSTERIOR VIEW OF PANCREAS)

no interference in the management of the diabetic patient has been reported with

VASODILAN®
(ISOXSUPRINE HCl)

TABLETS, 20 mg.

the compatible vasodilator

Mead Johnson LABORATORIES

© 1976 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL-54117

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

DATELINE

Dental, Oral Cancer Program Established

Houston, TX - The University of Texas M.D. Anderson Hospital and Tumor Institute and the Dental Branch of UT's Health Science Center at Houston have formed a joint Department of Dental Oncology. The program will include detailed oral examination as routine testing of every new cancer patient regardless of diagnosis and will participate in all phases of cancer patient care. Establishment of the department highlights importance of protecting oral cavity and teeth.

Alcoholics Helped Over Legal Hurdles

Madison WI - A public interest law firm here has initiated a program to remove barriers which prevent many recovered alcoholics, drug abusers, mentally ill persons, and ex-offenders from successfully making the transition back into society. Center for Public Representation assists in obtaining licenses to practice certain trades or professions, in seeking employment, credit, housing, insurance and bonding and utilizes advocacy, community education, training and research.

Memory in the Aged Is Studied

Rockville, MD - Contrary to the prevailing belief that memory declines with age, complaints of memory impairment in the aged may be associated with depression, rather than actual memory performance, according to a National Institute of Mental Health study. Study was conducted by R. L. Kahn, Ph.D. who suggests that memory complaints and actual performance depend on the interaction of depression and diminished brain function.

U.S. Federal Debt Is Fast Growing

Washington, DC - The Commerce Department has reported that the U.S. federal debt in 1975 grew at the fastest rate since World War II. Total net debt for government and private sector was $3 trillion at the end of 1975. Government's share was $741 billion, including $466 billion for the federal government. Federal increase of $85.5 billion from 1974 more than offset slower debt accumulation by state and local governments which increased 4.7 per cent.

Health Professionals Work as a Team

Birmingham, AL - University of Alabama is one of 10 universities nationally to be selected by Department of HEW to receive federal funds to implement a program for the training of health professionals to work as a team in total care of patients. Once in motion, UAB foresees team approach to health care as a remedy to fragmented health treatment and duplication of effort when one health professional is not aware of what another has done or is planning.

Sex Counseling Courses Offered

Free training workshops for physicians and nurses in S.A.F.E. Office Sex Counseling and Therapy will be offered through the Office of Continuing Medical Education, University of Kentucky Medical Center.

The workshops carry 24 hours of Category I credit for MDs.

For further information, write: Linda Carpenter, M.S., Coordinator, Center for Rational Behavior Therapy Training, Office of Continuing Medical Education (N204A), University of Kentucky Medical Center, Lexington, KY 40506.

Ochsner Foundation Sponsors G.I. Course

The Seventh Annual Postgraduate Course in Gastroenterology, "SMALL INTESTINE AND COLON: AN UPDATE," will be held Jan. 20-22, 1977, at Ochsner Medical Institutions Monroe Hall, New Orleans. Program director is William D. Davis, Jr., M.D., and co-director is Chesley Hines, Jr., M.D.

This seventh annual course in gastroenterology will present up to date information on advances in the understanding of the physiology and the pathophysiology of the small intestine and the colon, as well as disease states of the bowel. Although designed primarily for the generalist, material will be considered in sufficient depth to be of interest to specialists in the fields as well. Registration fee is $125.00.

America's greatest self-help program.

Red Cross. The Good Neighbor.

A Public Service of This Magazine & The Advertising Council Ad Council

LIBRIUM®
(chlordiazepoxide HCl)
5 mg, 10 mg, 25 mg capsules

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

EXPERIENCE. STILL YOUR HIGHEST AUTHORITY.

The discovery of Librium at Hoffmann-La Roche represented a landmark in psychotherapeutics. And, more specifically, a landmark in the treatment of anxiety and anxiety-related conditions.

Today, the acceptance of Librium by the medical community is based firmly on experience. And on a well-documented clinical record.

A record so voluminous it had to be put into a computerized storage and retrieval system.

Take the matter of safety, for example.

Experience with millions of patients indicates that the most common side effects of Librium are dose-related and, therefore, largely avoidable. There appears to be a low potential for dependence. Tolerance rarely develops. Few cases of known toxicity have been reported. However, patients should be cautioned about possible combined effects with alcohol and other CNS depressants.

Librium seldom produces adverse effects on the cardiovascular or respiratory



system. It is used concomitantly with many primary medications, such as cardiac glycosides, antihypertensive agents, anticholinergics, diuretics, antacids and anticoagulants. It should be noted that variable effects on blood coagulation have been reported very rarely in patients receiving Librium and oral anticoagulants; however, a causal relationship has not been established clinically.

Experience. Yours and ours. Together they make the task of choosing an antianxiety agent much simpler.

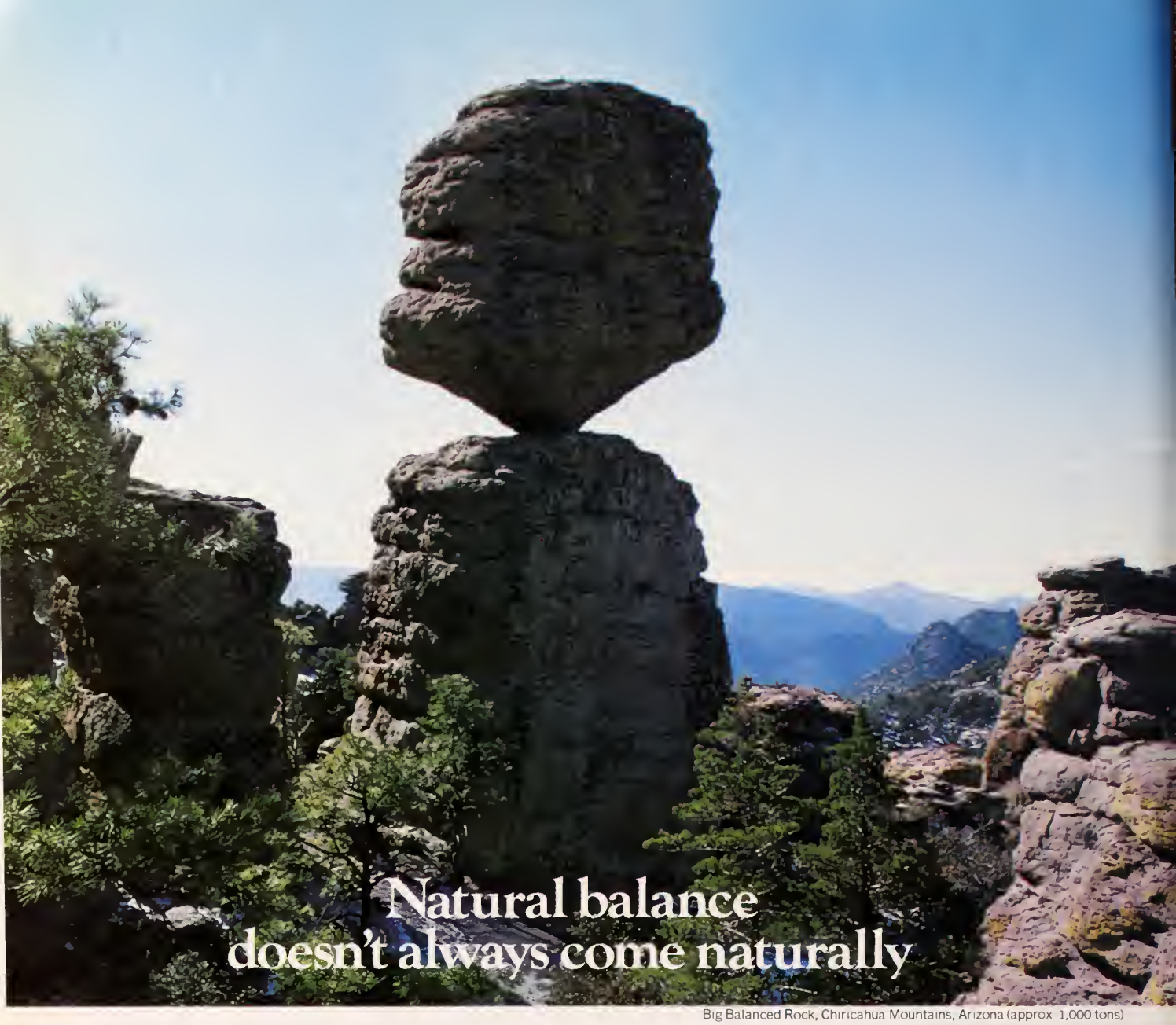
LIBRIUM® (IV)

chlordiazepoxide HCl/Roche

ROCHE

THE ANXIETY-SPECIFIC

Please see summary of product information on opposite page.



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

■ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

■ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*

■ **Dosage for Vertigo*** —The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25



(meclizine HCl) 25 mg. Tablets

for vertigo*

AMA Clinical Convention Set for Philadelphia

The 30th Clinical Convention of the American Medical Association will be held Dec. 4-7 in Philadelphia.

The convention will offer to physicians a broad-based, multi-disciplinary learning experience in continuing medical education. The scientific program is the largest and most comprehensive ever offered at an AMA clinical convention.

Some 47 postgraduate courses will be offered, along with nine general sessions, telecourses, living teaching demonstrations, and conducted exhibit rounds. In addition there will be 16 teaching luncheons and 32 "Meet the Professor" sessions.

Approximately 125 scientific exhibits will be offered on the latest developments in medicine in all areas, and some 100 commercial exhibits will present new pharmaceutical products and other new medical products and services.

The scientific program will take place in the Philadelphia Convention Center.

In conjunction with the scientific program the AMA's governing body, the House of Delegates, will convene at the Philadelphia Sheraton Hotel to conduct the official business of the association.

The nine general sessions will cover such topics as the National Health Planning Act; Recent Advances in Viral Vaccines; Diseases of the Thyroid; the CAT Scanner: Its Impact on Modern Diagnosis; Anaerobic Infections; Headache; Current Controversies in the Management of Breast Cancer, and Stress in Marriage.

The postgraduate courses will offer training in resuscitation of the heart attack victim, nutrition, evaluation of the dizzy patient, treatment of eye problems, blood disorders in children, heart disease, arthritis, diabetes, high blood pressure, fractures, emergency medicine, behavioral problems in children and adolescents, recent advances in cancer surgery, jaundice, mind-altering drugs, blood clots, allergies, and air pollution and its impact on health.

The "Meet the Professor" programs will include such subjects as heart valve replacement, asthma in children, hearing problems, eye problems, suicide prevention, rehabilitation of stroke patients, male infertility, breast cancer, obesity in adolescents, and dealing with hiatal hernia.

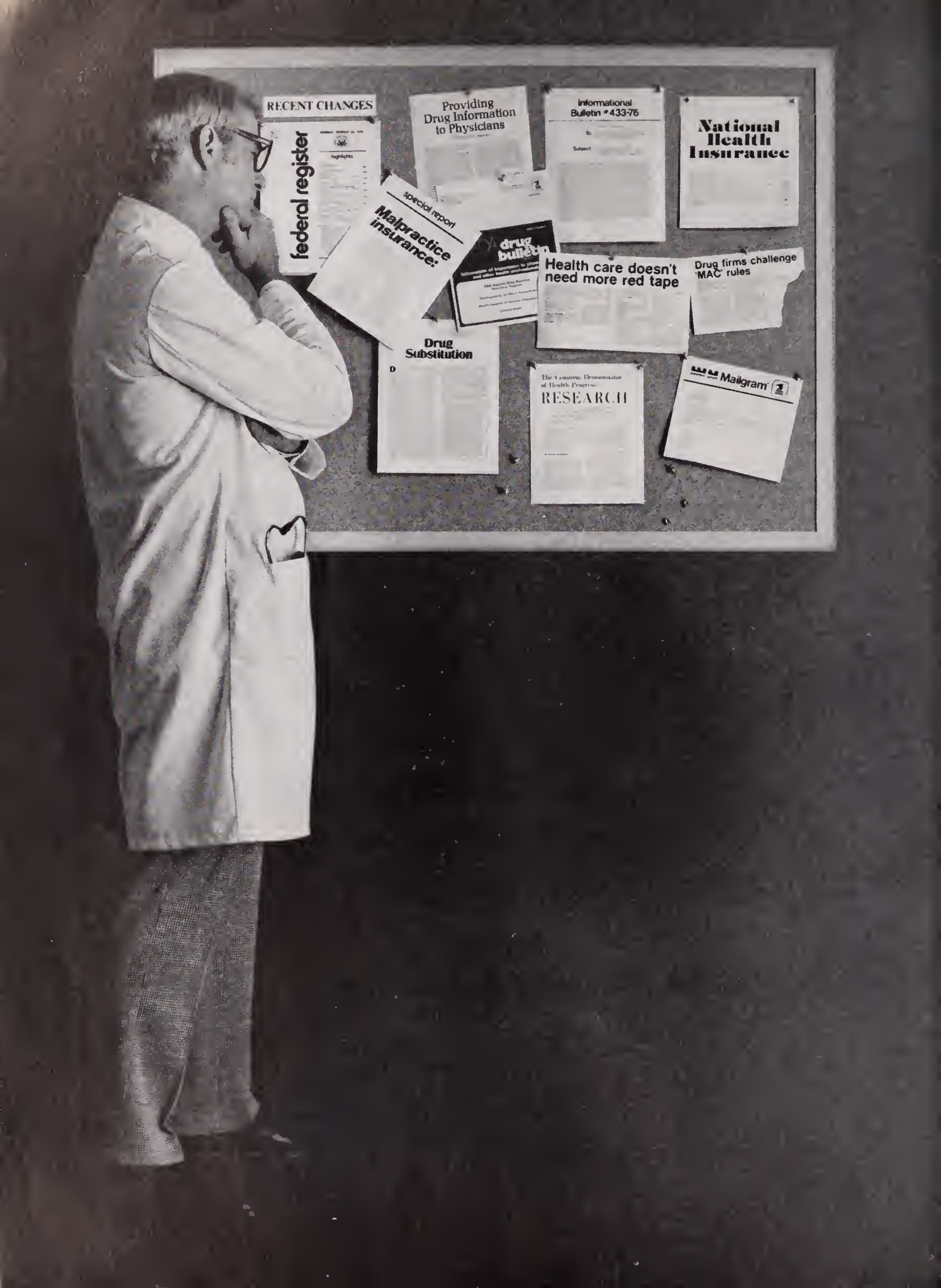
The luncheon sessions will cover topics such as participation in sports by girls, excessive fats in the blood, heart valve disorders, an update on drugs to treat infections, use of digitalis, the Pill, behavior therapy, sudden infant death, and care of the aging skin.

The complete program for the convention was published in the Oct. 11 issue of the *Journal of the American Medical Association.*

Applications are now being accepted for scientific exhibit space for the MSMA 109th Annual Meeting to be held May 2-5, 1977, in Biloxi.

For information, write to:

Chairman, Scientific Exhibits
MSMA
P.O. Box 5229
Jackson, MS 39216


RECENT CHANGES
federal register
Providing Drug Information to Physicians
Informational Bulletin #433-76
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Riverside.

Mississippi's Unique Psychiatric Hospital.

Riverside Hospital is unique in Mississippi.

As a privately owned 56-bed short term care facility for treating patients with psychiatric illness or emotional problems, it is the only hospital of its kind in the state.

Architecturally designed to create an attractive open environment, Riverside's "non-institutional" atmosphere helps prepare the patient for specific therapy, healthy entertainment and physical recreation.

The clinical program incorporates a wide range of modern psychiatric ideas. Emphasis is placed on interpersonal relationships, small group functions, and professional individualized care.

The Medical Staff includes a large number of physicians in private practice in the Jackson area. All are qualified and limit their practice to psychiatry.

Riverside is licensed by the Mississippi Commission on Hospital Care, and fully accredited by the Joint Commission on Accreditation of Hospitals.

For additional information contact: John R. Reedy, Executive Director.



Riverside Hospital

P.O. Box 4297, Jackson, MS 39216
Telephone: (601) 939-9030

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
November 1976, Vol. XVII, No. 11

ORIGINAL PAPERS

Idiopathic Scoliosis

BUFORD YERGER, JR., M.D.
Jackson, Mississippi

IDIOPATHIC SCOLIOSIS is a developmental abnormality of infancy through adolescence producing a lateral curvature of the spine. In spite of a great deal of research, the etiology of this progressive deformity remains obscure. Other causes of scoliosis are primarily congenital anomalies of the spine and various forms of spinal paralysis but these will not be the subject of this paper. Much of what applies to idiopathic curves, however, applies to these as well.

The incidence of idiopathic scoliosis varies among series between 1.2 and 11 per cent of the population.[1] There are three categories of idiopathic scoliosis. Infantile scoliosis is a relatively rare condition striking a high incidence of males and this is in the age group of birth to age three. Juvenile scoliosis occurs from ages three to 10 and adolescent curves from 10 to maturity.

The condition of most concern to the family practitioner is that of the juvenile and adolescent scoliosis. Almost 90 per cent of the adolescent scoliosis is in females. There is a definite familial tendency. In 100 consecutive patients treated at Alfred I. DuPont Institute, MacEwen reports that 43 per cent of the sisters and 29 per cent of the brothers of these patients had curves of at least 10 degrees.[2]

The single most important factor that must be understood in scoliosis is that all curves should be considered progressive. A very benign appearing curve in a 10-year-old child may progress to a horrible deformity in a 17-year-old female. Dorsal curves greater than 60 degrees may produce pulmonary hypertension and secondary cor pulmonale and in the lumbar area it is felt that severe curves in this area predispose one to back pain later in life.

Practicing orthopaedic surgeon, Jackson, MS.

Idiopathic scoliosis is a developmental abnormality of infancy through adolescence producing a lateral curvature of the spine. The author discusses the incidence of idiopathic scoliosis, diagnosis, treatment, surgical treatment, complications, and new developments. He points out that in scoliosis all curves should be considered progressive and that early diagnosis and treatment are very important.

It is reported in the Scandinavian literature that a significant number of patients with scoliosis do not marry.[3] Nachemson in 1968 reported in a 35 year followup of 117 scoliotics that nearly 50 per cent had some cardiopulmonary complication.[4] Collis and Ponsetti in a series of 195 scoliotics found that the decrease in vital capacity is directly proportional to the degree of scoliosis.[5]

DIAGNOSIS

Early diagnosis is the most important factor governing the eventual result in this deforming condition. There is a common misconception that growth must be complete before one can decide what should be done. Nothing could be further from the truth because with early diagnosis and treatment, progression of many of these curves can be prevented. Diag-

nosis is easily made by simple inspection of the spine with the patient standing. On forward bending a rib hump may be present even in early curves. In idiopathic scoliosis the convexity is almost always to the right with the rib hump being on the side of the convexity.

If in doubt, a *standing* x-ray of the spine should confirm the diagnosis. At the onset, many curves are barely visible even on x-ray but during the growth spurt may progress very rapidly up to 1 degree per month.

Any curve in a growing child must be assumed to be a progressive idiopathic curve and should be referred immediately so that early treatment can be begun to prevent progression. Unfortunately, a large number of curves seen in our clinic do not come in for treatment until some 18 to 20 months after the curve was first noted because members of the family, and on occasions even the family physician, were not aware of the potential hazards of the condition nor its tendency to progress.

TREATMENT

In growing children who have not reached maturity with curves under 35 degrees, brace treatment has an excellent chance of correcting the deformity. In the child who is nearing the completion of growth or already completed it, the Milwaukee brace has little to offer. The curve progresses in the growing child because of increased pressure on the concave growth plates of the vertebrae. This increased pressure reduces the mature height of these vertebrae on the concave side causing a wedge shaped vertebra which causes permanent deformity.

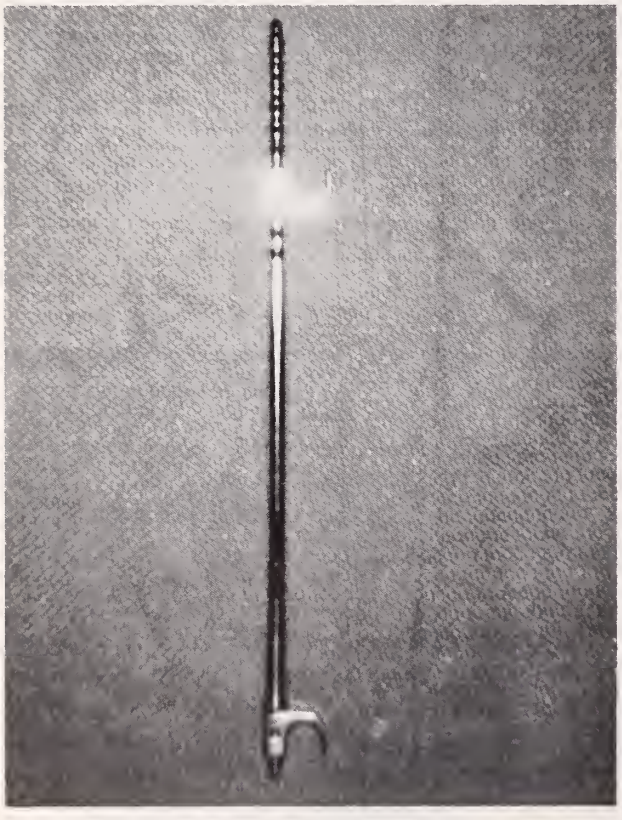


Figure 1. The Harrington Rod Apparatus.

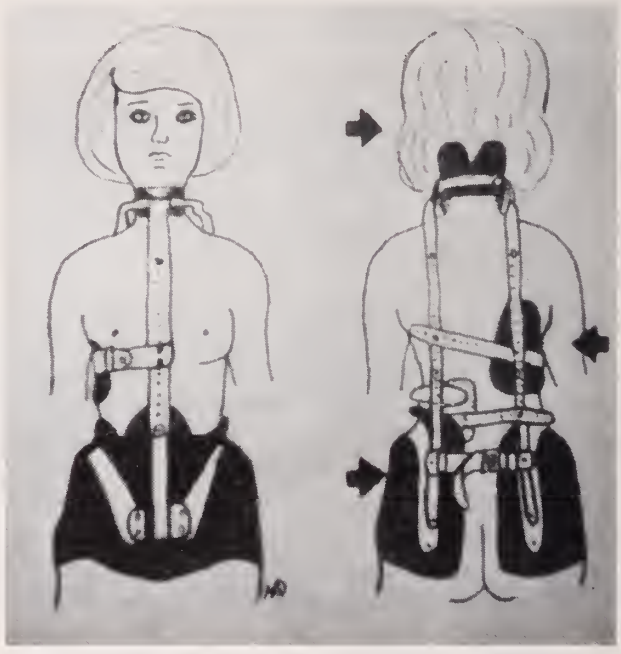


Figure 2. The Milwaukee brace used in nonoperative treatment.

The principle of the brace is to reduce by 3 point pressure the unequal pressures on the growth centers. Brace treatment requires dedication on the part of the child and the family, as well as the physician, and usually during the first year or two the brace is worn 23 out of 24 hours a day. The only restrictions in use of the braces are those activities where falls could be dangerous on the inflexible neck such as trampoline, horseback riding and contact sports. All other activities are vigorously encouraged. The brace is kept on until the completion of growth, that is in a girl, until a bone age of 15½ and bone age 16½ in the male. As growth is completed the brace is gradually weaned away until finally the child sleeps in the brace at night only for another year or two. The sooner the brace is applied, the shorter the total time in the brace and better the final correction.

SURGICAL TREATMENT

Surgical treatment in idiopathic scoliosis should be considered a salvage procedure and represents a



Figure 3. Preoperative photograph of patient with lumbar curve.

failure in early diagnosis. Most authorities feel that dorsal curves over 50 degrees in a mature child should be fused to prevent cardiopulmonary complications. Posterior fusion is also recommended by most authorities in lumbar curves over 40 degrees because of what is felt to be a high incidence of low back pain in these people. There are no exact statistics available for the incidence of low back pain in scoliosis.

In the early 1950s, Paul Harrington of Houston, TX, introduced the Harrington rod procedure which has helped significantly in the correction of these deformities. The Harrington rod is a spacer device which straightens the curve while the large fusion mass has a chance to mature and rigidly hold the curve in the corrected position. The procedure is an extensive one requiring fusion of an average of six to 10 vertebrae and requiring from two to six units of blood. It is the procedure at our clinic to place these children in a postoperative ambulatory cast one week after surgery for a total period of six months following the operation.

COMPLICATIONS

There are definite complications attendant to the procedure. In our series of 60 procedures, there have been four infections and two pseudoarthroses. According to the Scoliosis Research Society, there is a .5 per cent incidence of transient or permanent paralysis. This includes all types of scoliosis—congenital, paralytics and idiopathics.



Figure 4. Postoperative photograph of the same patient.

NEW DEVELOPMENTS

Recent articles by Worth Gross of Tulsa, OK, and Hugo Keim of Columbia Presbyterian Hospital report an increase in these curves in middle and late adulthood and also in younger women who have early pregnancy.[6] For this reason, victims of adolescent scoliosis must be followed for a lifetime and early fusion is performed before pain and irreversible cardiopulmonary changes occur.

SUMMARY

The most important factor in the management of scoliosis and the one that has the most significant effect on the eventual result is early diagnosis and

treatment. If Milwaukee brace treatment is instituted in a young, growing child, a satisfactory result can almost always be obtained. It is a common misconception to believe that growth must be completed before treatment can be begun. The child should be taken to a physician as soon as an abnormality is noticed. Surgical treatment is reserved for those severe curves which were not recognized early enough for brace treatment. REMEMBER, until proven otherwise, all scoliosis in a growing child is progressive.

★★★

727 Carlisle Street (39202)

REFERENCES

1. Brooks, Leon, et al: The Epidemology of Scoliosis, A Prospective Study. Orthopaedic Review, Vol. 1, No. 5, November, 1972.
2. MacEwen, Dean: A Look at the Diagnosis and Management of Scoliosis. Orthopaedic Review, Vol. III, No. 6, June, 1974.
3. Nachemson, A.: A Long Term Follow Up of Long Term Scoliosis. Acta Orthopaedic Arthrop. Scand. 39:46, 1968.
4. Lundgren, Nillsonne V.: Long Term Prognosis in Idiopathic Scoliosis. Acta Scandanavia 39:456, 1968.
5. Ponsetti, Collis D.: Long Term Follow Up of Patients With Idiopathic Scoliosis Not Treated Surgically. J. Bone Joint Surg. 51A:425, 1969.
6. Keim, H.: Scoliosis Can Progress in the Adult. Orthopaedic Review, Vol. 3, No. 2, February, 1974.

NATIONAL HOSPITAL STATISTICS: A TEN YEAR APPRAISAL

Item	*1975*	*1965*	*Per Cent Change*
U. S. Health Care Expenditures	$118 billion	$40.6 billion	191
Per cent of Gross National Product	8.3	5.9	40.7
Average per person in U. S.	$547	$209	61.8
Total spent for Hospital Care	$40 billion	$13.5 billion	196
Average per person in U. S.	$187	$69	171

The overall increase in health care cost during the past *25 years* breaks down into three categories. Source—*U. S. Department of Health, Education and Welfare:*

Increase in the U. S. Population	15 per cent
Increase in Services and Medical Techniques	39 per cent
Overall Inflation	46 per cent

Problems in Abdominal Surgery VI. Intestinal Obstruction From Peritoneal Carcinomatosis

WILLIAM O. BARNETT, M.D.
Jackson, Mississippi

THE PRECISE EXTENT of surgical therapy for the obstructed patient with abdominal metastatic carcinoma has continually posed a troublesome challenge for physicians. There has been an inclination, at least among some observers, to conclude that these unfortunate individuals are best managed by minimal to no attempt at relief of obstruction, and only to maintain relief from discomfort in view of a hopeless situation. Indeed, this position may be valid in some circumstances. However, we are persuaded that a more aggressive approach is currently appropriate, and that significant extension of good quality life can be achieved in some cases.[1, 2] An accurate identification of the obstructing mechanism can be accomplished in many instances only after exploratory laparotomy. The offending lesion may be represented by a single adhesion which can be corrected with minimal effort. The widespread application of chemotherapy has increased longevity in some patients and will undoubtedly improve over the years. Many of these lesions are relatively slow growing, which may allow the patient several years of comfortable life before encroachment upon vital structures has occurred.

Responsible Primary Tumors. The frequency with which metastatic tumors are responsible for intestinal obstruction is directly related to the incidence of the primary tumor. Carcinoma of the left colon is particularly prominent among these lesions. It is one of the more common of the abdominal malignancies and it involves both sexes. When the lesion reaches an advanced stage of growth after breaking through the bowel serosa, the malignant cells shed from the tumor and seed the entire peritoneal lining. Carcinomatosis of the ovary represents another common lesion responsible for intestinal obstruction as a result of peritoneal metastasis. Metastatic melanoma may behave uniquely when it involves the small bowel, usually the jejunum, and produces a lesion which includes the inner as well as the outer bowel wall layers. Intestinal obstruction results from a combination of the lumen occupying position of the tumor as well as the frequent precipitation of intussusception.

From the Department of Surgery, University of Mississippi Medical Center, Jackson, MS.

The author, professor of surgery at the University Medical Center, writes about intestinal obstruction from peritoneal carcinomatosis. He discusses responsible primary tumors, diagnosis, management, blind loop syndrome, closed loop syndrome and ends with an illustrative case report.

Peritoneal carcinomatosis responsible for bowel obstruction most often involves the lower one half of the peritoneal cavity. Carcinoma of the lower colon and ovaries are anatomically in the area. Gravity encourages the settling out of malignant tumor cells in the pelvis. These factors are operative in localizing intestinal obstruction to the ileum in the majority of instances, especially during the initial course of the illness.

DIAGNOSIS

The possibility of intestinal obstruction should be considered when the patient complains of cramping abdominal pain, nausea and vomiting, and abdominal distention. Additional supportive evidence includes obstipation and failure to pass gas per rectum. Physical findings characteristic of the condition are abdominal distention, hyperactive bowel sounds (early), occasional peristaltic tinkles (late) and a resonant percussion note. Plain, flat and erect abdominal films are of enormous value in finalizing the diagnosis. Highly suggestive of the condition are

dilated small bowel, air fluid levels and absence of gas in the colon (see Figure 1).

MANAGEMENT

The advisability of operative intervention where complete bowel obstruction prevails has been mentioned above. We feel that this approach is especially advisable where previous operative assessment of the extent of peritoneal involvement has not been carried out. There are some circumstances where the terminal stage of the illness is being approached and long tube utilization constitutes the favored approach. The minimal incidence of bowel gangrene under these circumstances is reassuring.

Where operative management is contemplated, passage of a long tube well into the bowel during the preoperative period constitutes a helpful achievement. Preoperative bowel decompression is laudable and the tube is very helpful in maintaining postoperative bowel decompression during the interval before peristalsis returns. Small bowel intubation is also helpful during execution of the operation in differentiating between segments above and below the site of obstruction.



Figure 1. Erect plain film of small bowel obstruction.

Certain objectives are worthy of pursuit during the operative management of intestinal obstruction from metastatic tumor. Colostomy should be avoided or deferred as late into the illness as possible. In many instances extensive pelvic carcinomatosis will exist for a long period without obstructing the colon. It is, indeed, necessary to obtain a preoperative barium enema in order to establish the extent of colon patency. A determined effort should be made to maintain as much small bowel absorptive surface in the circuit as possible. This may necessitate multiple entero-enterostomies. It is also desirable to preserve as much ileum as possible in view of its unique role in vitamin B_{12} and bile salt absorption. With the short circuiting and consequent loss of considerable small bowel, troublesome diarrhea may pose a threat. This consideration underscores the importance of preservation of ileocecal valve function where this is possible.

A decision must be made in these cases as to whether or not satisfactory palliation can be achieved by dissecting the individual bowel loops free to reestablish bowel continuity or whether to go ahead with a bypass procedure. The former approach has a relatively narrow application in view of the usual widespread peritoneal involvement. When it is feasible, the lower small bowel should probably be "tacked" up as high in the abdomen as possible. The bypass procedure usually necessitates only one side-to-side anastomosis early in the course of the disease. This usually involves a loop of small bowel going into the pelvis and one coming out. When the tumor has extended to the terminal ileum in close proximity to the ileocecal valve, bypass side-to-side ileocolostomy should be employed. When multiple loops of small bowel are involved, with significant, uninvolved, intervening segments, then multiple, side-to-side enterostomies are indicated in order to preserve as much small bowel absorptive surface as possible.

Blind Loop Syndrome. Bypassed bowel segments, which still communicate with the functional bowel lumen, may constitute a site of intestinal stagnation and are referred to as blind loops (see Figure 2). This problem, to some extent, is related to the length of the loop to and from the site of obstruction. It is desirable to make the segments relatively long in order to place the anastomoses a safe distance from the tumor. On the other hand, the longer the loops, the more likely is the development of the blind loop syndrome. The problem is apparently related to bac-

terial overgrowth in the stagnant bowel. Clinical manifestations include diarrhea, steatorrhea, anuria, weight loss, abdominal pain and vitamin deficiency. Resolution of these problems may be achieved by the administration of oral antibiotics and parenteral vitamins.

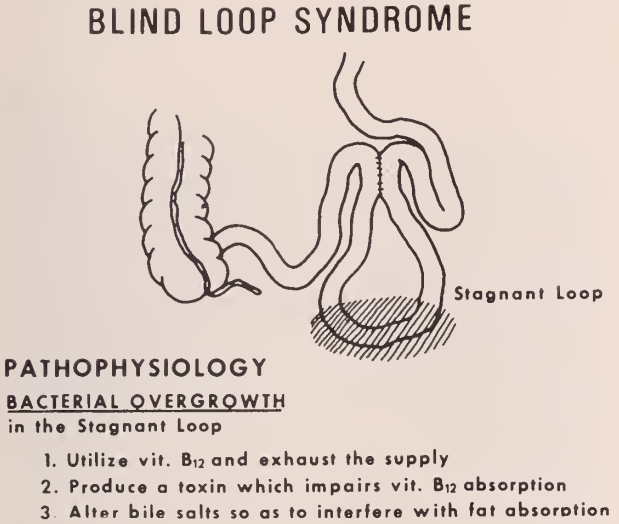


Figure 2

Closed Loop Syndrome. Another bothersome problem relates to segmental obstruction with a relatively normal intervening bowel segment. The lumen is not in continuity with the alimentary tract which significantly lowers the bacterial flora. It does continue to secrete mucus which ultimately produces significant distention with abdominal discomfort and nausea. This condition can also result from obstruction of the colon in face of a competent ileocecal valve. Such a recent case responded satisfactorily to cecostomy (see Figure 3). Where transection of the small bowel is necessary, the distal portion may well be brought onto the surface of the abdominal wall as a mucous fistula. Side-to-side loop bypass procedure lends a measure of protection against closed loop problem.

CASE REPORT

H. B., a 48-year-old female was hospitalized with a history of the diagnosis of adenosarcoma of the right ovary with peritoneal metastasis having been established during exploratory laparotomy three months previously. At the time of this admission, she complained of cramping, abdominal pain, nausea, vomiting, obstipation and the inability to pass gas per rectum. Plain abdominal film revealed evidence of small bowel obstruction (see Figure 1). At laparotomy, the pelvic area of the abdominal cavity revealed widespread carcinoma with about one foot of the terminal ileum solidly entrapped in the tumor mass. The left colon also disappeared into the tumor mass but preoperative barium enema and proctoscopic examination proved this segment of bowel to be patent. A segment of upper ileum was selected and anastomosed side-to-side to the ascending colon.

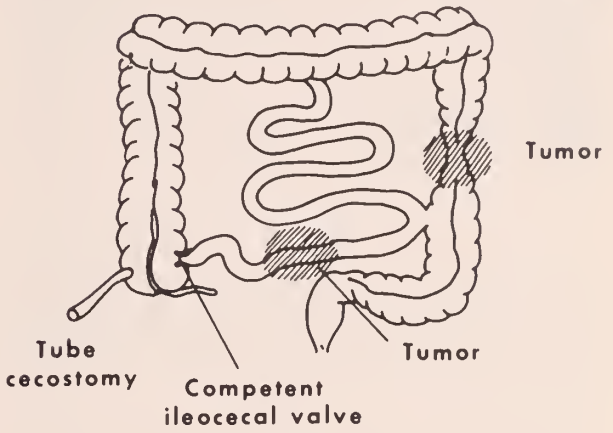


Figure 3

Her recovery was uneventful and the alimentary tract remained patent for almost two years during which time she received chemotherapy. She recently returned with the clinical picture of complete bowel obstruction and at operation the small bowel proximal to the obstruction was again anastomosed to the colon. She is now able to satisfy nutritional demands by the oral route and continues to maintain a satisfactory quality of life.

SUMMARY

An aggressive, optimistic approach should be employed for many patients with intestinal obstruction resulting from metastatic abdominal carcinomatosis. Operative intervention will reveal the cause of the obstruction and permit relief by the use of appropriate surgical techniques in a significant number of cases. While cure cannot be expected, worthwhile palliation is often achieved when combined with chemotherapy. Complications, such as the blind loop syndrome and closed loop problems, should be recognized early in order to permit effective management. ★★★

2500 North State Street (39216)

REFERENCES

1. Glass, R. L. and Le Duc, R. J.: Small Intestinal Obstruction From Peritoneal Carcinomatosis. Am. J. Surg. 125:316, 1973.
2. Schwartz, G. F., et al: Combined Hyperalimenation and Chemotherapy in Treatment of Disseminated Solid Tumors. Am. J. Surg. 121:169, 1971.

Radiological Seminar CLXIV: Angiographic Localization of Bleeding Diverticulosis of the Colon: A Case Report

JERRY T. RUSSELL, M.D., and
CHARLES A. MARASCALCO, M.D.
Vicksburg, Mississippi

IT HAS BEEN SHOWN that approximately 5 to 10 per cent of persons over the age of 40 have diverticulosis of the colon and 10 to 30 percent of these individuals develop varying degrees of rectal bleeding. When considering all cases of severe rectal bleeding, 70 per cent are found to be secondary to diverticulosis of the colon.

Conservative management is successful in approximately 80 per cent of the cases of bleeding colonic diverticula, but if 4 or more units of blood are required over a 24 hour period or if two or more recurrent episodes of bleeding occur which require transfusions, surgery should be considered. If surgery is performed, all segments of the colon bearing diverticula should probably be resected to prevent postoperative rebleeding.[1] Total abdominal colectomy has been adopted as standard policy at San Francisco General Hospital when the source of colonic hemorrhage is in doubt. Visceral angiography can help: (1) by demonstrating that diverticulosis of the colon is indeed the source of bleeding prior to performing a total colectomy,[2] (2) by allowing segmental resection in a poor risk patient who might not tolerate total colectomy, or (3) by making possible arterial infusion of vasopressors for the control of acute bleeding while preparing a poor risk patient for an eventual nonemergency procedure.[1] The following case demonstrates our utilization of angiography in the evaluation of recurrent severe rectal bleeding.

CASE REPORT

This 78-year-old woman was initially admitted in April 1975 for rectal bleeding which subsided spontaneously and required no replacement blood transfusions. A barium enema performed April 11, 1975, revealed marked generalized diverticulosis of the colon with the greatest number of diverticula being concentrated in the distal descending and sigmoid areas (see Figure 1).

The patient was again admitted through the emergency room on Jan. 6, 1976, with the sudden onset of severe rectal bleeding. Admission hemoglobin was 9.6 grams per cent and the hematocrit was 30.3 per cent. Several hours later the hemoglobin had



Figure 1. Barium enema demonstrating marked generalized diverticulosis with the greatest degree of involvement located in the descending and sigmoid portions.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Vicksburg Clinic, Vicksburg, MS.

dropped to 8.6 grams per cent and the hematocrit dropped to 26 per cent. Blood transfusions were begun but bleeding continued. Selective superior and inferior mesenteric arteriography, performed on Jan. 8, 1976, demonstrated active arterial bleeding into the lumen of the distal descending colon (see Figures 2A, B, C). After five units of blood had been given and the bleeding continued, a left hemicolectomy with anastomosis of the transverse colon to the upper rectum or distal sigmoid was performed. Two additional units of blood were required during surgery. The postoperative course was satisfactory and the patient has done well during the subsequent 6 months.



Figure 2. Inferior mesenteric arteriogram. A. Early arterial phase.



Figure 2B. Capillary phase with leakage of contrast medium from a branch of the left colic artery into the lumen of the distal descending colon.



Figure 2C. Venous phase with further accumulation of contrast medium.

SUMMARY

A 78-year-old woman with the second episode of rectal bleeding was demonstrated by angiography to have hemorrhage from a diverticulum of the distal descending colon. After five units of replacement blood had been given, a left hemicolectomy was performed. There has been no recurrence of bleeding during the following 6 months. Visceral angiography can be helpful in similar cases: (1) by localizing the site of bleeding, whether treated conservatively, by segmental resection, or total colectomy, and (2) by allowing arterial infusion of vasopressors for primary control of bleeding or temporary control while preparing a poor risk patient for surgery. ★★★

3311 I-20 Frontage Rd. (39180)

REFERENCES

1. Parsa, F., Gordon, H. E. and Wilson, S. E.: Bleeding Diverticulosis of the Colon: A Review of 83 Cases. Dis. of Colon and Rectum 18:37-41, Jan.-Feb. 1975.
2. Blaisdell, F. W.: Management of the Acute Complications of Diverticular Disease: Hemorrhage. Dis. of Colon and Rectum 19:287-288, May-June 1976.

Inflation: When your child gets his first job at an income you dreamed of as the culmination of your career.

MSMA: You're Ten Years Older Than You Think!

LAURA D. S. STURDIVANT
Jackson, Mississippi

THE MISSISSIPPI STATE MEDICAL SOCIETY was founded in January 1846, ten years before the date it has been thought that a statewide medical association existed. In November 1845, the well-established Natchez Medical Society called for a statewide convention of physicians to be held in Jackson to form a state medical society. Although originally planned for May 1846 (a notice to that effect appeared in the Paulding, Mississippi, *True Democrat,* November 12, 1845), the meeting date was moved up to the second Monday in January 1846.

Interest in the formation of a state medical association was evident in several areas of the state. A north Mississippi newspaper, the *Ripley Advertiser,* on November 22, 1845, published the following notice: "The physicians of Tippah are to meet to appoint delegates to the state convention suggested by the Natchez Medical Society to meet at Jackson on the second Monday of January next." Another medical association, the Medical Society of North Mississippi, had been active as early as 1842: the "regular meeting of the Medical Society of North Mississippi on the first Monday of May next" was announced in the *Holly Springs Gazette,* March 25, 1842.

Further notice of the proposed statewide meeting was carried in the *Jackson Southron* on November 26, 1845: "MEDICAL. There will be a convention of physicians in this city on the second Monday of January next. Meetings to appoint delegates have been held in Natchez, Vicksburg, &c."

Human nature peeps out of the following communication published in the *Woodville Republican,* January 24, 1846. (Dan Marble was a highly popular actor of the nineteenth century who usually toured the South during the months of winter and early spring.)

> Editorial Correspondence.
> JACKSON, Miss.
> Jan. 12, 1846
>
> DEAR SIR:
>
> . . . The Medical Convention met this evening at 4 o'clock in the Senate Chamber, but as there were no more than 25, and many more were looked for on the evening train of cars, we adjourned to meet at 8 o'clock tonight, when again many of the members begged to be let off to see Dan Marble, and as the meeting was first set on foot by Dr. Cartwright, who arrived but tonight and was not prepared to explain the subject of the meeting, we adjourned to 8 o'clock, tomorrow, A.M.
>
> Yours, &c.,
> A. R. K.*

Dr. Samuel A. Cartwright, a distinguished physician-surgeon then practicing medicine in Natchez, was widely known and respected both in the practice of his profession and as a prolific contributor to medical journals and other media, including the prestigious national magazine, *DeBow's Review;* the *Medical Recorder* of Philadelphia, Pennsylvania; and the *New Orleans Medical and Surgical Journal.* On September 24, 1824, the *Natchez Southern Luminary* reported that a "bronchotomy" had been performed on "a child of Mrs. Wicks of Natchez by Dr. Cartwright." In 1826, he received a "Medal from Harvard" for his essay on "Malignant fever," noted in *The Ariel* (Natchez), January 2, 1826. On April 25, 1828, *The Ariel* announced that Samuel

---

Editor's Note: Laura D. S. Sturdivant's previous articles on medical history appeared under her former name of Laura D. S. Harrell. For eight years she was a publications writer (medical sciences) with the U. S. Army Medical Service, BAMC, in San Antonio, and with CDC, USPHS, Atlanta. She recently retired from her position as editor, Mississippi Department of Archives and History, Jackson, and assistant editor, *Journal of Mississippi History.*

* Probably Dr. A. R. Kilpatrick of Woodville; see below.



Samuel A. Cartwright, M.D. Lithograph preceding his article, "Slavery in the Light of Ethnology," in E. N. Elliott, Cotton Is King, and Proslavery Arguments: Comprising the Writings of Hammond, . . . Bledsoe, and Cartwright. . . . *(Augusta, Ga.: 1860), 691-728. Reproduced through the courtesy of the Mississippi Department of Archives and History, Jackson.*

A. Cartwright, M.D., had been elected an honorary member of the Ohio Medical and Philosophical Society. Throughout the years, the Natchez and New Orleans (where he later practiced) newspapers published many of his essays. In 1848 he engaged the redoubtable Dr. Daniel Drake in a controversy concerning cholera. In 1846, when he was elected first president of the Mississippi State Medical Society, he was at the height of his powers.

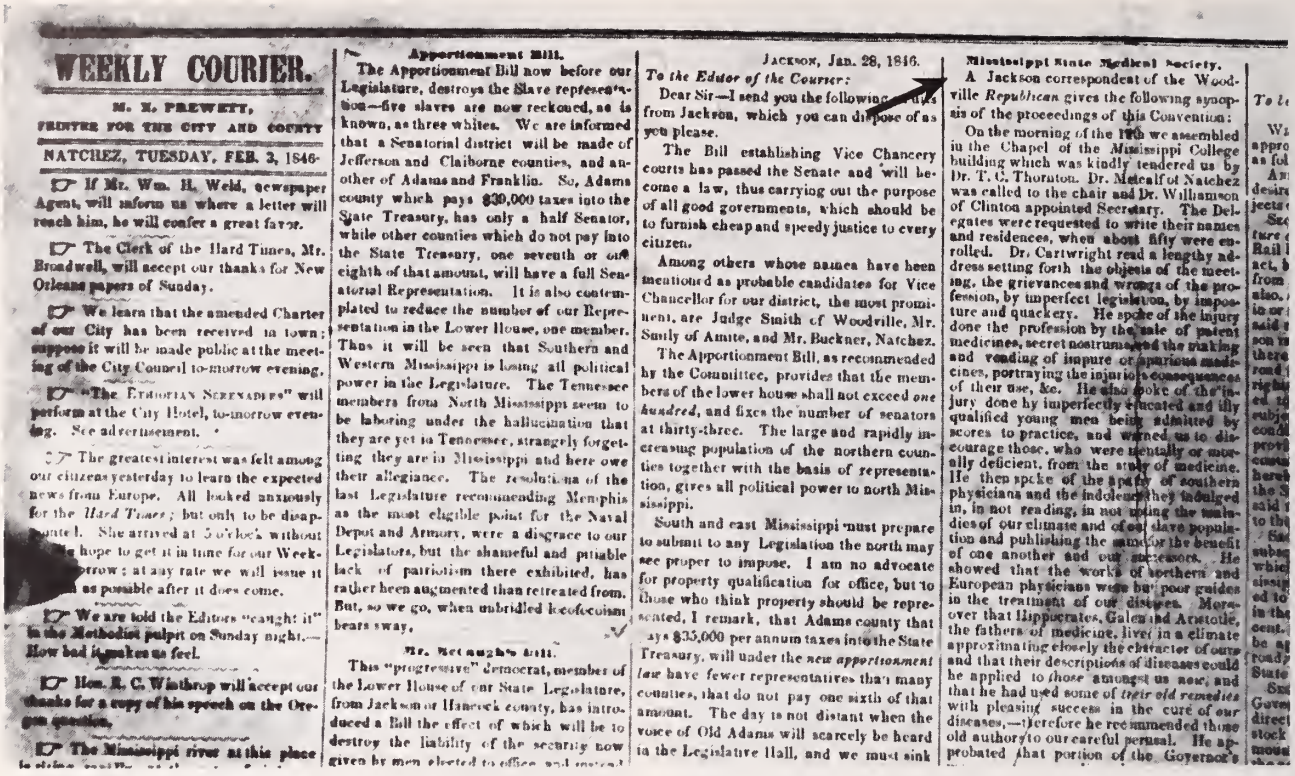
On January 28, 1846, *The Mississippi Democrat,* published at Carrollton, announced that the state medical convention had ". . . resolved itself into a state medical society."

A long account of the meeting was published in the *Natchez Weekly Courier and Journal,* February 3 [4], 1846. The first full session was held on January 13 in the Chapel of Mississippi College, as the legislature had gone into session in the Capitol. Dr. [J. T.?] Metcalf of Natchez was called to the chair to preside until the election of officers, and Dr. [William B.] Williamson of Clinton was appointed secretary. About 50 delegates enrolled. Dr. Cartwright read a lengthy address "setting forth the objects of the meeting, the grievances and wrongs of the profession, by imperfect legislation, by imposture and quackery." He spoke of "the injury done the profession by the sale of patent medicines, secret nostrums, and the making and vending of impure or spurious medicines, portraying the injurious consequences of their use, &c. . . ." He also discussed the "injury done by imperfectly educated and illy qualified young men being admitted by scores to practice, and warned us to discourage those who were mentally or morally deficient, from the study of medicine. . . ." Dr. Cartwright also "approbated" Governor Albert Gallatin Brown's recommendation for the establishment of an "Asylum for the Insane &c."

Dr. Cartwright then proposed that the state establish "Registers of Births and Deaths in each county and keep a record of the diseases and kinds of medical advice in attendance on each case. . . ." He suggested that the "system of ethics" of the Natchez Medical Society be used by the Mississippi State Medical Society, and it was adopted by the latter.

On January 14, 1846, Dr. [G. G.] Banks of Hinds County moved the formation of a state medical society, and the first officials elected were Dr. Samuel A. Cartwright of Natchez, president; Dr. [W. S.] Langley of Jackson, first vice-president; Dr. [J. S.] Copes of Jackson, second vice-president; and Dr. [William B.] Williamson of Clinton, secretary.

A called meeting of the Mississippi State Medical Society was held on March 25, 1846, in Jackson, to chose delegates from the society to attend the national convention "to be held in the city of New York in May next." The Paulding, Mississippi, *True Democrat,* April 15, 1846, reported that the delegates chosen were Drs. Mount and Leggett of Washington [Miss.]; A. R. Kilpatrick, Woodville; C. S. Mayoun, Wilkinson County; J. T. Metcalf, Natchez; W. Bahour and —— Stiles, of Vicksburg; G. G. Banks, Hinds; W. J. Leake, W. P. Sayle, Yazoo City; G. Keirn, James Maynork, Holmes County; —— Stansbury, Carroll County; J. S. Copes, Jackson; D. Lipscomb, Robt. Lanter, Columbus; W. Strother, Monticello; —— Andrews, Jefferson County; —— Abby, Port Gibson; W. Jemison, J. Pittman, Holly Springs; George Nicholson, Pike; —— Bordwell, "Octibbeha." ". . . On motion, it was resolved that the president, Dr. Samuel A. Cartwright be added to the delegation. . . ." The meeting,



WEEKLY COURIER.

M. K. PREWETT,
PRINTER FOR THE CITY AND COUNTY

NATCHEZ, TUESDAY, FEB. 3, 1846.

☞ If Mr. Wm. H. Weld, newspaper Agent, will inform us where a letter will reach him, he will confer a great favor.

☞ The Clerk of the Hard Times, Mr. Broadwell, will accept our thanks for New Orleans papers of Sunday.

☞ We learn that the amended Charter of our City has been received in town; suppose it will be made public at the meeting of the City Council to-morrow evening.

☞ "The Ethiopian Serenaders" will perform at the City Hotel, to-morrow evening. See advertisement.

☞ The greatest interest was felt among our citizens yesterday to learn the expected news from Europe. All looked anxiously for the *Hard Times;* but only to be disappointed. She arrived at 5 o'clock without [illegible] hope to get it in time for our Weekly to-morrow; at any rate we will issue it as possible after it does come.

☞ We are told the Editors "caught it" in the Methodist pulpit on Sunday night.—How bad it makes us feel.

☞ Hon. R. C. Winthrop will accept our thanks for a copy of his speech on the Oregon question.

☞ The Mississippi river at this place

Apportionment Bill.

The Apportionment Bill now before our Legislature, destroys the Slave representation—five slaves are now reckoned, as is known, as three whites. We are informed that a Senatorial district will be made of Jefferson and Claiborne counties, and another of Adams and Franklin. So, Adams county which pays $30,000 taxes into the State Treasury, has only a half Senator, while other counties which do not pay into the State Treasury, one seventh or one eighth of that amount, will have a full Senatorial Representation. It is also contemplated to reduce the number of our Representation in the Lower House, one member. Thus it will be seen that Southern and Western Mississippi is losing all political power in the Legislature. The Tennessee members from North Mississippi seem to be laboring under the hallucination that they are yet in Tennessee, strangely forgetting they are in Mississippi and here owe their allegiance. The resolutions of the last Legislature recommending Memphis as the most eligible point for the Naval Depot and Armory, were a disgrace to our Legislators, but the shameful and pitiable lack of patriotism there exhibited, has rather been augmented than retreated from. But, so we go, when unbridled licentiousness bears sway.

Mr. McNaughs's Bill.

This "progressive" democrat, member of the Lower House of our State Legislature, from Jackson or Hancock county, has introduced a Bill the effect of which will be to destroy the liability of the security now given by men elected to office, and [illegible]

Jackson, Jan. 28, 1846.

To the Editor of the Courier:

Dear Sir—I send you the following [illegible] from Jackson, which you can dispose of as you please.

The Bill establishing Vice Chancery courts has passed the Senate and will become a law, thus carrying out the purpose of all good governments, which should be to furnish cheap and speedy justice to every citizen.

Among others whose names have been mentioned as probable candidates for Vice Chancellor for our district, the most prominent, are Judge Smith of Woodville, Mr. Smily of Amite, and Mr. Buckner, Natchez.

The Apportionment Bill, as recommended by the Committee, provides that the members of the lower house shall not exceed *one hundred*, and fixes the number of senators at thirty-three. The large and rapidly increasing population of the northern counties together with the basis of representation, gives all political power to north Mississippi.

South and east Mississippi must prepare to submit to any Legislation the north may see proper to impose. I am no advocate for property qualification for office, but to those who think property should be represented, I remark, that Adams county that pays $35,000 per annum taxes into the State Treasury, will under the *new apportionment law* have fewer representatives than many counties, that do not pay one sixth of that amount. The day is not distant when the voice of Old Adams will scarcely be heard in the Legislative Hall, and we must sink

Mississippi State Medical Society.

A Jackson correspondent of the Woodville *Republican* gives the following synopsis of the proceedings of this Convention:

On the morning of the 12th we assembled in the Chapel of the Mississippi College building which was kindly tendered us by Dr. T. C. Thornton. Dr. Metcalf of Natchez was called to the chair and Dr. Williamson of Clinton appointed Secretary. The Delegates were requested to write their names and residences, when about fifty were enrolled. Dr. Cartwright read a lengthy address setting forth the objects of the meeting, the grievances and wrongs of the profession, by imperfect legislation, by imposture and quackery. He spoke of the injury done the profession by the sale of patent medicines, secret nostrums and the making and vending of impure or spurious medicines, portraying the injurious consequences of their use, &c. He also spoke of the injury done by imperfectly educated and illy qualified young men being admitted by scores to practice, and warned us to discourage those, who were mentally or morally deficient, from the study of medicine. He then spoke of the apathy of southern physicians and the indolence they indulged in, in not reading, in not noting the maladies of our climate and of our slave population and publishing the same for the benefit of one another and our successors. He showed that the works of northern and European physicians were but poor guides in the treatment of our diseases. Moreover that Hippocrates, Galen and Aretotle, the fathers of medicine, lived in a climate approximating closely the character of ours and that their descriptions of diseases could be applied to *those* amongst us now, and that he had used some of *their old remedies* with pleasing success in the cure of our diseases,—therefore he recommended those old authors to our careful perusal. He approbated that portion of the Governor's

The Natchez Weekly Courier and Journal, *February 4, 1846, p. 2. This, the editorial page, carried the date on which the editorial was written, instead of the date of publication, a common practice in the 19th century. Reproduced through the courtesy of the Mississippi Department of Archives and History, Jackson.*

which had been presided over by first vice-president W. S. Langley in the absence of Dr. Cartwright, adjourned until ". . . the next regular stated meeting on the first Tuesday in May next."

In 1847, the Mississippi State Medical Society met in Jackson on the second Tuesday in January to elect officers and delegates to the national convention, and in 1848 met on Tuesday, January 11, and in May.

Thus it is seen that the Mississippi State Medical Association which held its first meeting in 1856 (see James Grant Thompson, M.D., *History of the Mississippi State Medical Association* [2nd ed., 1949], 7) was preceded by the Mississippi State Medical Society. According to contemporary newspaper accounts, semi-annual meetings of the society were held in January and May. So, as far as the formation of a statewide medical association is concerned, the date of birth was January 14, 1846. ★★★

820 Arlington Street (39202)

Cost analysis of 13¢ stamp: 10 cents of postage, 3 cents for storage.

Announcing
A Pioneering Self-Assessed
Educational Program for the
Practicing Physician

THE HYPERTENSION MEDICAL KNOWLEDGE SELF-ASSESSMENT PROGRAM

A project of The Editorial Board of
Dialogues in Hypertension
in conjunction with
The National Board of Medical Examiners

CME ACCREDITATION

As an organization accredited for Continuing Medical Education, the American Heart Association certifies this continuing medical education offer meets the criteria for 40 credit hours in Category I for the Physician's Recognition Award.

Acceptable for 40 prescribed hours by the American Academy of Family Physicians.

ENROLLMENT

You can enroll now at no cost.
For full details, see your Smith Kline &French Representative, or write: Health Learning Systems, Inc., P.O. Box 7929, E-72, Philadelphia, PA 19101.

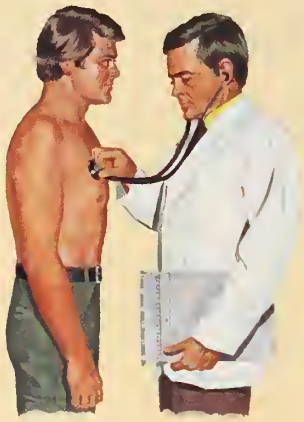
Developed and produced by Health Learning Systems, Inc., under an educational grant from Smith Kline &French Laboratories.

Narrowing down pneumonias

Upjohn

Bacterial or nonbacterial?

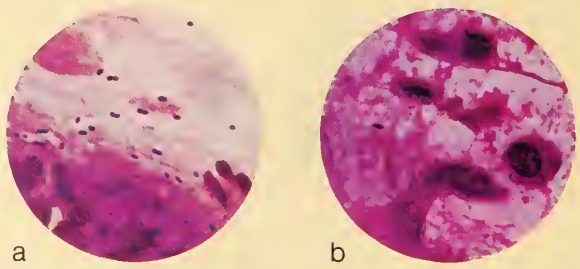
In the early stages of mild to moderate pneumonia, it is often difficult to reach an accurate bacteriologic diagnosis. A tentative differentiation may be made on history-taking, physical examination, CBC with differential analysis, and microscopic study of the sputum smear. Specimens should be obtained for culture and sensitivity testing, but when a bacterial pneumonia is diagnosed, therapy is often instituted before the etiological agent is positively identified.



Bacterial pneumonias may have a sudden onset with a shaking chill, rapid development of fever, pleuritic pain, and cough productive of rust-colored sputum. The Gram-stained sputum smear generally shows polymorphonuclear neutrophils as well as a predominance of the causative organisms. These are likely to be *Streptococcus pneumoniae,* still by far the most frequently encountered agent in bacterial pneumonia.[1] The CBC reveals marked leukocytosis with a shift to the left.

In *nonbacterial pneumonias*—mycoplasmal or viral—classical symptoms tend to develop more slowly, with myalgia, lassitude, and headache predominating. Sputum production is usually scanty, and the sputum smear is relatively uninformative, showing gram-positive cocci and other organisms which are part of the normal pharyngeal flora. The leukocyte count is normal or slightly elevated.

Direct Gram-stained sputum smears. (a) Pneumococcal pneumonia—note abundant polymorphonuclear leukocytes, as well as gram-positive diplococci. (b) Nonspecific—consistent with viral or mycoplasmal pneumonia. Note large mononuclear cell, as well as a few polymorphs and mixed bacterial flora (pharyngeal contaminants).



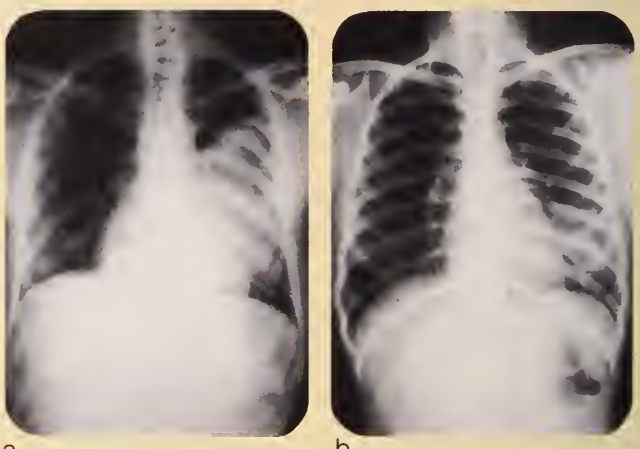
a b

Mycoplasmal or viral?

Differentiation between mycoplasmal and viral pneumonias may be impossible in the acute stage.[2]

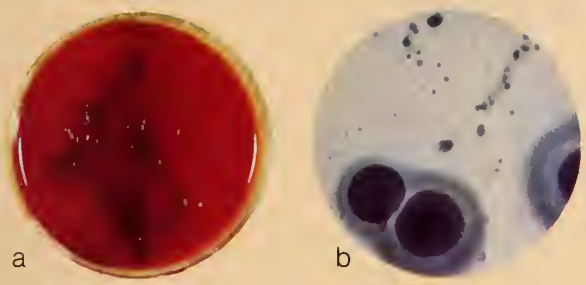
Serologic testing and culture methods for *Mycoplasma pneumoniae* are complex and time-consuming, taking as long as two weeks after obtaining samples. The sensitivity and specificity of the test for cold agglutinins have been questioned. The complement-fixing antibody test may reflect previous infection. Furthermore, facilities for culturing *M. pneumoniae* are not widely available.[3]

If treatment is to be initiated, therefore, it may be necessary to start on the basis of a *presumptive* diagnosis of mycoplasmal pneumonia.[1-3] In reaching such a diagnosis, the physician relies on clinical judgment, considering such factors as the age of the patient and the history of exposure. For example, *Mycoplasma pneumoniae* is considered the most common cause of pneumonia among ambulatory patients aged 20 to 35.[1]



a b

Chest x-rays of patients with (a) pneumococcal pneumonia—classically heavy, extensive infiltration of left lung; (b) mycoplasmal pneumonia—mild infiltrate confined to left lower lobe. Roentgenography usually does not help in differential diagnosis, since both types of pneumonias may present with a wide spectrum of x-ray as well as clinical findings.



(a) Distinct mucoid colonies of type 3 pneumococci *(Streptococcus pneumoniae)* on sheep blood agar showing greenish discoloration (alpha-hemolysis) of medium. (b) Typical "fried-egg" colonies of *Mycoplasma pneumoniae* consisting of dense central core with lighter periphery. Cultural and serologic methods for detecting *M. pneumoniae* are complex, time-consuming, and not widely available.

Expectant therapy

In the patient with a presumptive diagnosis of mycoplasmal pneumonia or bacterial pneumonia, it may be desirable to initiate antibiotic therapy before culture and sensitivity results are available.

A course of erythromycin or tetracycline is considered effective in the treatment of mycoplasmal pneumonia to help speed the clearing of infiltrate and shorten the duration of symptoms.[1,3] In pneumococcal pneumonia, erythromycin is an effective alternative to penicillin, the drug of choice. A recent report, based on data from 200 hospitals of 100 beds or more, found 98% of *S. pneumoniae* sensitive *in vitro* to erythromycin.[4]

Among these therapeutic agents, only erythromycin provides effective coverage of both *Mycoplasma pneumoniae* and *S. pneumoniae*. The penicillins are not effective against *Mycoplasma*, and *S. pneumoniae* has shown a relatively high incidence of resistance to tetracycline.

When erythromycin is selected for therapy, E-Mycin (erythromycin enteric-coated tablets, Upjohn) is a good choice. E-Mycin is administered and absorbed as active erythromycin base, and may be taken q.i.d., q 6h, or b.i.d., immediately after meals or between meals. Thus, patients can use mealtimes to help them remember their medication. The enteric coating on E-Mycin tablets helps ensure efficient absorption in the intestinal tract, and bioavailability studies show that E-Mycin can be expected to produce predictable, acceptable blood levels. The low cost of E-Mycin helps assure economical therapy.

E-Mycin rarely causes serious side effects and is not associated with liver toxicity.* The most frequent side effects are upper gastrointestinal, such as abdominal cramping and discomfort, and are dose-related. Nausea, vomiting, and diarrhea occur infrequently with usual oral doses. Serious allergic reactions, including anaphylaxis, have rarely been reported.

*Use cautiously in patients with severe liver impairment

REFERENCES: 1. Chusid EL, Dalrymple W, Holloway WJ, et al: Managing the infectious pneumonias. *Patient Care* 9:122-167, 1975. 2. The occasional might of mycoplasma. *Emergency Med* 7:82, 85, 1975. 3. Stevens DA: Viral and Mycoplasma pneumonias. *Postgrad Med* 55:81-86, 1974. 4. Data source: PMR Bacteriologic Report, Winter Series 1975-1976. Data are a compilation of laboratory reports submitted during December 1975 and January and February 1976 by 200 acute care hospitals of 100 beds or more

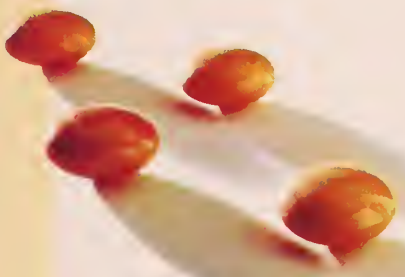
Please turn page for brief summary of prescribing information.

Summary

Because pneumonias may be difficult to differentiate at the outset, treatment is often initiated before a causal diagnosis is made. However, readily available diagnostic criteria occasionally allow early differentiation between bacterial and nonbacterial pneumonias. When the diagnosis appears to be nonbacterial pneumonia, further differentiation between mycoplasmal pneumonia and viral pneumonia is more complex and time-consuming. Therefore, therapy is often initiated on the basis of a *presumptive* diagnosis of mycoplasmal pneumonia.

Erythromycin is an effective antibiotic against *Mycoplasma pneumoniae, Streptococcus pneumoniae,*† and *Streptococcus pyogenes.*† E-Mycin (erythromycin enteric-coated tablets, Upjohn) is administered and well absorbed as the active base, may be taken immediately after meals or between meals, and is essentially nontoxic.

†Although penicillin remains the drug of choice against these organisms, erythromycin is an effective alternative



E-Mycin® 250 mg

erythromycin enteric-coated tablets, Upjohn

wide-ranging usefulness in pneumonia*

*Mild to moderately severe, due to susceptible organisms

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001, U.S.A.
© 1976 The Upjohn Company J-5122-9

Wide-ranging usefulness in pneumonia*

E-Mycin® 250 mg

erythromycin enteric-coated tablets, Upjohn

Upjohn

- For mild to moderately severe infections due to susceptible organisms that commonly invade the respiratory tract
- Essentially nontoxic (see Precautions and Adverse Reactions below)
- Documented bioavailability
- May be taken immediately after meals or between meals
- Active base formula produces predictable blood levels
- Formulated for quality...priced for economy

E-MYCIN® TABLETS — 250 mg — For Oral Administration (erythromycin enteric-coated tablets, Upjohn)
E-Mycin Tablets are especially coated to protect the contents from the inactivating effects of gastric acidity and to permit efficient absorption when administered either immediately after meals or when given between meals on an empty stomach.

Indications: *Streptococcus pyogenes (group A beta-hemolytic streptococci):* Upper and lower respiratory tract, skin, and soft-tissue infections of mild to moderate severity. Parenteral benzathine penicillin G is considered by the American Heart Association to be the drug of choice in the treatment and prevention of streptococcal pharyngitis and in long-term prophylaxis of rheumatic fever. When oral medication is necessary (because the parenteral route is contraindicated) or if there is known allergy to penicillin, the following recommendations made by the American Heart Association apply: 1) Oral penicillin G or V (where no allergy exists)—This is the drug of choice. Give for a minimum of 10 days; 2) Erythromycin—Give for a minimum of 10 days. A few strains of streptococci resistant to erythromycin have been reported.
Alpha-hemolytic streptococci (viridans group): Short-term prophylaxis against bacterial endocarditis prior to dental or other operative procedures in patients with a history of rheumatic fever or congenital heart disease who are hypersensitive to penicillin. (Erythromycin is not suitable prior to genitourinary surgery where the organisms likely to lead to bacteremia are gram-negative bacilli or the enterococcus group of streptococci.)
Staphylococcus aureus: Acute infections of skin and soft tissue of mild to moderate severity. Resistance may develop during treatment.
Diplococcus pneumoniae: Upper respiratory tract infections (eg, otitis media, pharyngitis) and lower respiratory tract infections (eg, pneumonia) of mild to moderate degree.
Mycoplasma pneumoniae (Eaton agent, PPLO): In the treatment of primary atypical pneumonia, when due to this organism.
Treponema pallidum: Infections due to this organism.
Corynebacterium diphtheriae and *Corynebacterium minutissimum:* As an adjunct to antitoxin, to prevent establishment of carriers, and to eradicate the organism in carriers. In the treatment of erythrasma.
Entamoeba histolytica: In the treatment of intestinal amebiasis only. Extraenteric amebiasis requires treatment with other agents.
Listeria monocytogenes: Infections due to this organism.

Contraindication: Contraindicated in patients with known hypersensitivity to erythromycin.

Warning: Safety for use in pregnancy has not been established.

Precautions: Erythromycin is principally excreted by the liver. Caution should be exercised in administering the antibiotic to patients with impaired hepatic function. Surgical procedures should be performed when indicated.

Adverse reactions: The most frequent side effects of erythromycin preparations are gastrointestinal, such as abdominal cramping and discomfort, and are dose-related. Nausea, vomiting, and diarrhea occur infrequently with usual oral doses. During prolonged or repeated therapy, there is a possibility of overgrowth of nonsusceptible bacteria or fungi. If such infections occur, the drug should be discontinued and appropriate therapy instituted. Mild allergic reactions such as urticaria and other skin rashes have occurred. Serious allergic reactions, including anaphylaxis, have been reported.

Treatment of overdosage: The drug is virtually nontoxic, though some individuals may exhibit gastric intolerance to even therapeutic amounts. Allergic reactions associated with acute overdosage should be handled in the usual manner—that is, by the administration of adrenalin, corticosteroids, and antihistamines as indicated and the prompt elimination of unabsorbed drug, in addition to all needed supportive measures.

How supplied: 250 mg enteric-coated tablets—in bottles of 100 and 500 tablets, and in unit-dose packages of 100 tablets. Caution: Federal law prohibits dispensing without prescription.

For additional product information, consult the package insert or see your Upjohn Representative.

NAS-4

The Upjohn Company, Kalamazoo, Michigan 49001, U.S.A.

©1976 The Upjohn Company

J-5122-9

*Mild to moderately severe, due to susceptible organisms

POSTGRADUATE CALENDAR

Nov. 8-12, 1976

NEPHROLOGY INTENSIVE COURSE
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine, Department of Family Medicine and University Medical Center, Division of Continuing Health Professional Education with support from Mississippi Regional Medical Program.

Coordinator:
John D. Bower, M.D., professor of medicine and director of the Artificial Kidney Unit, the University of Mississippi School of Medicine

This clinically oriented one-week course will emphasize the reversible and treatable forms of kidney disease. It provides an indepth analysis of acute kidney failure management and control of the reversible features of chronic kidney disease. Participants will cover physiology, pathology, radiology, immunology, urology, transplantation, and hemodialysis in clinical nephrology. Fee: $125.00. Credit: 40 contact hours, 4.0 CEU, Category I, AMA; AAFP.

Dec. 2, 1976

EARLY DETECTION OF HEAD AND NECK CANCER: A MULTIDISCIPLINARY APPROACH
Holiday Inn North, Hattiesburg

Sponsored by the University of Mississippi School of Nursing, University Medical Center Division of Continuing Health Professional Education, and the National Cancer Institute Project for Head and Neck Cancer in cooperation with the American Cancer Society, Mississippi Division, Inc.

Coordinator:
Dale E. Clark, M.M.S., coordinator, Mississippi Head and Neck Cancer Network, the University of Mississippi Medical Center

Open to physicians, dentists, RNs, LPNs, dental hygienists, and dental auxiliaries, this session is one in a series planned to give health professionals new information about head and neck cancer, with emphasis on early detection, coordinated treatment, and total rehabilitation. Program objectives are to identify, field test, and evaluate available and new methods in a limited number of communities for the detection, diagnosis, staging, treatment, and rehabilitation of patients with head and neck cancer. Supportive data collected will be used to determine the program's practicality and acceptability prior to dissemination into the wider cancer control community programs. Other sessions are planned for McComb, Feb. 17; Meridian, April 20; and Greenville, May 10. Fee: $10.00. Credit: 6 contact hours, .6 CEU, Category I, AMA; AAFP.

Dec. 2-3, 1976

INFECTIOUS DISEASE INTENSIVE COURSE
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine and University Medical Center Division of Continuing Health Professional Education with support from Mississippi Regional Medical Program

Coordinator:
William Lockwood, M.D., associate professor of medicine, the University of Mississippi School of Medicine

Guest faculty are Dr. P. K. Pankey, chief of the infectious disease division at Ochsner Clinic in New Orleans, La., and Dr. John Cleveland, Jr., head of special health services, Dade County Health Department, and consultant to the Center for Disease Control for Venereal Disease, Miami, FL. Participants in the two-day course will discuss antimicrobial agents and newly released antibacterial drugs along with clinically useful antiviral agents. Swine influenza and the venereal disease epidemic will be covered, and recent advances in understanding non-gonococcal urethritis will be presented.

The University of Mississippi Medical Center Division of Continuing Health Professional Education offers intensive refresher courses to meet physicians' clinical practice needs in the specialties most requested. Mississippi Regional Medical Program partially supports the series, open to all physicians. Intensive courses are eligible for AMA Physician Recognition Award Category Credit. Enrollment is limited, and applications are accepted in the order received. All correspondence about intensive and other courses should be addressed to Continuing Education, University Medical Center, 2500 North State Street, Jackson, MS 39216.



The President Speaking

CME and the "Good Physician"

LYNE S. GAMBLE, M.D.
Greenville, Mississippi

THIS PAST MONTH the American Medical Association mailed materials about the AMA "Physician's Recognition Award" to every physician in the country. This voluntary award is given to physicians who earn it by completing continuing medical education requirements.

I recall the words of Dr. Hugh Morgan when I was in medical school at Vanderbilt to the effect that the good physician would be a student all of his life. Certainly this is even more true for our profession today because of rapid scientific advances that have occurred and continue.

The AMA Physician's Recognition Award provides a means of documenting continuing medical education for a physician in any field of medicine. It is only one mechanism that our profession has structured to identify and document the fact that we are "good physicians."

Others exist such as the CME program of the American Academy of Family Physicians. There is coordination between these programs. For example, the AMA Physician Recognition Award Program endorses the CME program of the AAFP. Additionally, most of our specialty organizations offer both CME programs and programs to evaluate the individual physician. The former usually provide CME hours that meet requirements for the AMA Physician Recognition Award.

Sixty of the required 150 hours of CME for the AMA award must be in what is called Category I or prescribed hours. These hours are gained by participating in a planned program of CME which is evaluated in terms of an educational objective for the participants. Ideally, the educational objective is based on identified CME needs of the participants. Some of the kinds of CME activities which we all participate in and which can be developed to meet the definition of a Category I program are medical audit studies, grand rounds and local scientific seminars.

Our MSMA Council on Medical Education now surveys and accredits local hospitals and medical organizations offering programs of CME for physicians. Only an accredited source can offer Category I CME hours. It is in our interest to encourage our local hospitals and specialty societies to seek accreditation.

At MSMA's next annual session the Council on Medical Education will present a plan to the House of Delegates to require CME as a condition of membership. Some 22 state medical associations and national specialty societies now have such a membership requirement. We have an opportunity here to establish the standards and procedures to document that we are "good physicians." ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XVII, NUMBER 11
NOVEMBER 1976

EDITORIALS

Physicians Beware! Medicine Is Being Assaulted

The practice of medicine as we know it is being assaulted today on a variety of fronts. Our institutions which have been designed to insure quality training programs, quality graduates, and continuing quality of care to all patients through various specialty board certification, peer review, and licensing agencies are about to be bypassed legislatively.

An ever growing number of groups are seeking to be legislated into the active practice of many different parts of what we all clearly see as clinical medicine. It is imperative that all physicians recognize this threat to the public welfare and take steps to reverse these very dangerous trends.

More specifically, these groups are composed of what have been thought of for the most part as technicians. They have slowly upgraded their own definition of themselves, become increasingly organized, and embarked on intensive—and expensive—legislative forays. They are attempting to convince legislators of many different things, but in every case they seek greater privilege and usually a redefinition of their "specialty." They want enlarged scope—statutorily.

Unfortunately, in some areas of the country the blitz of lobbying and no-expense-spared type of legislative activity has paid off for them. In some states laws have been passed which permit optometrists to use drugs in their offices. No clear line is always drawn to differentiate the diagnostic or therapeutic use of these drugs. They seek to diagnose disease, qualify for insurance and state agency, such as medicaid, payments, and most incredibly of all, they seek on a national level to become the *primary point of entry* into the health care system for *all* patients with eye problems.

They divine that they have the capability to decide which patients need further workup and to whom they should be sent. This, mind you, from a group who have *no* medical background whatever. They claim a lot of scientific courses which would supposedly prepare them for this role, but these are given by non-medical instructors in their non-medical schools.

In a similar manner, audiologists are actively seeking greater definition and restrictions in their area. It has been proposed in many regulations, for example, that the use of hearing aids be solely at the discretion of an audiologist. Not, mind you, an otologist or otolaryngologist, but a non-medical audiologist.

We are all too familiar with the ridiculously unscientific farce of chiropractic and what they are attempting to gain legislatively. I have seen articles that indicate that naturopaths, whatever they may be, are seeking legal status to diagnose "those diseases which they are qualified to follow" and they are as best I can determine primarily in the health food and nutrition area. Who under heaven thinks that they can be qualified to screen the public and rule out pathology to determine what patients "fit" their specialty.

There has never been a time when it was more important to "enlighten" your legislators about what it takes to look after the health of the public. It must be repeatedly emphasized to them that the complicated process of educating a physician simply

cannot be bypassed and substituted with a technical education in a specific specialty or subspecialty area. To practice medicine you must be a physician first —a specialist second.

MYRON W. LOCKEY, M.D.
Associate Editor
Jackson, MS

Medicaid Costs and Controversy

The Mississippi Medicaid Commission has requested a $166 million appropriation for the 1977-78 fiscal year, an increase of some $15 million over this fiscal year's budget.

Appearing before the State's Commission on Budget and Accounting last month Medicaid officials cited increased hospital and nursing home costs as some of the primary reasons for the budget increase. The Commission on Budget and Accounting serves as the legislature's fiscal advisor and watchdog.

Medicaid, which began as a $40 million program to purchase health services for some 200,000 recipients in 1970, will expend some $150 million on 300,000 plus recipients in 1976. An $11 million "ceiling" on state appropriations that the legislature placed on the program in 1970 has been increased each year. This year's state appropriation for the program will total some $38 million.

There was much controversy in the 1976 Mississippi Legislature concerning the dramatic increases in Medicaid expenditures and the state's ability to continue to fund such increases even at a favorable "federal match." In an effort to "hold the line" and reduce expenditures the Medicaid Commission ordered several changes in the drug program this summer, one of which required recipients to make a copayment of 50¢ on each prescription. The move has drawn heavy fire from civil rights groups. The drug program is not a required Medicaid benefit for purposes of receiving federal matching funds.

About one-half of this year's Medicaid service dollars will be expended on hospital and nursing home services. The latter service will account for $41 million of the total $150 million expended for health services this year although only some 6,000 Medicaid recipients will receive nursing home services. Drug services will account for about 19 per cent of total expenditures, followed by physician services at 17 per cent of total expenditures.

Physicians' services under Medicaid are paid for, by law, in accordance with what is called the "Blue Shield F-300 Surgical Schedule." It is the only Medicaid payment tied to a fixed schedule and the only payment not increased since the program was enacted.

The physicians' schedule was less than customary fees in Mississippi when the Medicaid program began in 1970. Five years later, with an over 38 per cent increase in costs of goods and services as reflected by the Consumer Price Index, the schedule is absolutely ridiculous.

A diminishing number of Mississippi physicians are participating in the Medicaid Program leading to what one Medicaid official predicts will be an increasing number of $100,000 plus physicians whose names are reported annually in the Mississippi press.

The annual reporting of Medicaid providers receiving more than $100,000, which is also required by law, continues as a "dramatic news story." This is in spite of efforts by MSMA and the Medicaid Commission to indicate that gross payments for medical services have little, if nothing, to do with the quality, necessity or costs of providing such services.

Mississippi is not alone in its "Medicaid problems." A majority of the nation's governors have called for the federal government to assume total responsibility for the program because of fiscal problems their states are having with the program. There have been national charges of fraud and abuse in the program and so-called "Medicaid mills" in New York and several other large states have been the subject of recent Congressional inquiries.

Medicaid was enacted by Congress in 1965 and hailed as a federal/state program to purchase health services for our needy citizens. Few of its original sponsors claim any credit for the program today.

CHARLES L. MATHEWS

LETTERS

SIRS: I am currently engaged in research on the Munchausen (Hospital Addiction) Syndrome and its variants. I would like to correspond with any other physicians who have had personal contact with such patients. To this end I would appreciate it if you would print this letter in your Correspondence (or Letters) section. All responses should be addressed to me at: 5620 Netherland Avenue, Riverdale, New York 10471, U.S.A. S. E. HYLER

Book Review

Principles of Clinical Electrocardiography. 9th edition. By Mervin J. Goldman, M.D. 412 pages with illustrations. Los Altos: Lange Medical Publications, 1976. $9.50.

Principles of Clinical Electrocardiography, now in its ninth edition, is an excellent text to introduce and explore the subject of electrocardiography in clinical medicine. It is well worth the reader's investment in cost and time, whether as a basic source for the inexperienced or as a reference text for the veteran electrocardiographer. Since its initial publication in 1956, *Principles of Clinical Electrocardiography* has been updated and expanded at two to three year intervals, incorporating in its revisions the most current of clinical and experimental information. In doing so, the book remains popular with students of electrocardiography regardless of their level of experience.

Recognizing the impossible task of presenting examples of all the infinite variations in the electrocardiogram, the author has admirably fulfilled his goal, set forth in his preface, to present the "basic concepts of clinical electrocardiography and their clinical application." For the most part, the book is well illustrated, both diagrammatically for clarity and ease of understanding, and in actual ECG reproductions. Description of electrophysiological phenomena are concise and lucid. The volume is well referenced, a factor which allows the reader who is interested in more indepth discussion an easy access to the abundant literature on clinical scalar electrocardiography and related disciplines.

The present edition has an enlarged section on pacemakers, and additional attention has been given to certain of the arrhythmias, including sick sinus syndrome, brady-tachycardia syndromes, and accelerated idioventricular rhythms. The section on spatial vectorcardiography and corrected orthogonal lead systems provides a brief but excellent introduction to the subject. Modern techniques of investigation such as His bundle electrograms are illustrated and the utility in the diagnosis of arrhythmias discussed. Current concepts of hemiblocks are also well summarized.

Finally, there is an appendix, providing many interesting and illustrative ECG's for interpretation by the reader in order that he may examine his own interpretative skills. The author's interpretations with discussions to explain them when required are, of course, provided.

A weakness, if there is one, appears to be in the field of pediatric electrocardiography. Apart from major positional abnormalities in the newborn, little space is devoted to the development of a normal electrocardiogram in growing children.

In summary, *Principles of Clinical Electrocardiography* places at the fingertips of the clinician a wealth of useful and practical information. It is well organized, clearly written, easily read, concisely summarized, and beautifully illustrated. With its modest cost, in addition to its other attributes, it will most certainly continue to be one of the most popular and widely used texts available.

BENJAMIN M. CARMICHAEL, M.D.
Hattiesburg, MS

Medico-Legal Brief

MALPRACTICE PANEL'S RECOMMENDATION ON LIABILITY BARRED AT TRIAL OF SUIT

The portion of New York's medical malpractice legislation permitting introduction of a medical malpractice panel's recommendation at trial is unconstitutional, a New York trial court ruled.

A medical malpractice suit was brought, seeking damages for a postoperative infection allegedly due to negligence in failing to remove gauze from an infant patient's body. Pursuant to New York law, a hearing was held before a medical malpractice panel. The panel, consisting of a physician, an attorney, and a Justice of the Supreme Court, unanimously found that there was no liability on the part of the defendants.

In accordance with the New York legislation, the panel members signed the formal written recommendation indicating their concurrence on the question of liability and forwarded it to all parties to the suit. The legislation provided in the event of such unanimity, the panel's recommendation would be admissible in evidence at any subsequent trial upon the request of any party to the action.

Ruling on the constitutionality of this portion of the malpractice legislation, the court said, "To allow the panel's recommendation to be introduced into evidence would nullify plaintiff's constitutional right to a meaningful jury trial." Even though the legislation provided that the recommendation of the panel would not be binding upon the jury or, in a case tried without a jury, upon the trial court, the court said, ". . . to anticipate anything less than a full and complete adoption by the jury of the panel's recommendation as to liability is unrealistic and strains credulity."

The trial court also pointed out that although the legislation permits trial examination of panel members, this examination is limited. A panel member may be examined only on the recommendation and cannot testify on any statements or opinion made during the hearing.

Moreover, only the physician and attorney members of the panel can be called to testify. As to the third member, a Supreme Court Justice, the court said, ". . . his impartiality and integrity are considered of such magnitude that, not only can his determination not be impeached, but the legislature saw fit not even to allow for the taking of his testimony for a limited purpose. . . . Consequently, his determination and recommendation would not be perceived by the juror merely as a recommendation made in his capacity as a member of the panel, but rather on a higher plane."

Accordingly, the court ruled that in the malpractice suit in which the panel found for the defendants the recommendation of the panel would be suppressed and not admitted into evidence. The court added that although it found a portion of the New York malpractice legislation unconstitutional, its ruling would not invalidate the entire statute.—*Comiskey v. Arlen,* 45 LW 2019 (N.Y.Sup.Ct., July 2, 1976)



WARREN, GENE, Vicksburg. Born Carriere, MS, July 14, 1944; M.D., University of Mississippi School of Medicine, Jackson, MS, 1969; interned St. Paul Hospital, Dallas, TX, one year; radiology residency, same, 1971-74; elected by West Mississippi Medical Society.

BRIEF SUMMARY OF
PRESCRIBING INFORMATION
ANTIMINTH® (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

One swallow does it



eliminates Pinworms and Roundworms with a single dose

- **Single dose effectiveness against both pinworms and roundworms**— The only single-dose anthelmintic effective against pinworms *and* roundworms.
- **Nonstaining** — to oral mucosa, stomach contents, stools, clothing or linen.
- **Well tolerated** — the most frequently encountered adverse reactions are related to the gastrointestinal tract.
- **Economical** — a single prescription will treat the whole family.
- **Highly acceptable** — pleasant-tasting caramel flavor.
- **Convenient** — just 1 tsp. for every 50 lbs. of body weight. May be taken without regard to meals or time of day.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Please see prescribing information on facing page. NSN 6505-00-148-6967

Antiminth® ORAL SUSPENSION
(pyrantel pamoate) equivalent to 50mg pyrantel/ml

PERSONALS

H. Maynard Bellamy, Jr., announces the opening of his offices for the practice of internal medicine and gastroenterology at the Medical Plaza on Vancleave Road in Ocean Springs.

Peter A. Boelens of Vicksburg attended a pediatrics seminar at the Children's Hospital Medical Center at the Harvard Medical School.

Richard C. Boronow of Jackson and UMC presented a paper, "Comparison of two radiotherapy treatment plans for cervix cancer," at the American Association of Obstetricians and Gynecologists meeting at Hot Springs, VA.

Benjamin M. Carmichael, of Hattiesburg, Martin H. McMullan and James A. Joransen of Jackson have been granted fellowship in the American College of Cardiology.

Francis R. Conn of Hattiesburg announces a leave of absence from his practice of orthopaedic surgery for a period of six months to one year to become associated with the Joint Commission on Accreditation of Hospitals.

Woody Davis of Meridian has been elected to a three-year term beginning Jan. 1, 1977, on the Board of Directors of the Greater Meridian Chamber of Commerce.

Paul E. Edwards, Jr., announces the opening of his practice of family medicine in the Davis Shopping Center in Pelahatchie.

Charles N. Floyd of Gulfport has been elected president of the Harrison County chapter of the American Cancer Society, Mississippi Division, by the society's board of directors.

W. M. Gorton of Belzoni was re-elected chief of staff of the Humphreys County Memorial Hospital at the recent meeting of the medical staff. Toxey E. Hall was re-elected secretary.

Walter C. Gough has joined the medical staff of the Choctaw (Indian) Health Department in Philadelphia.

Armin F. Haerer of Jackson and UMC participated in a Society of Clinical Neurologists annual seminar in San Diego and worked on a combined publication with other physicians at Wadsworth Hospital Center in Los Angeles.

Clyde O. Hagood, Jr., announces the opening of his office at the Coastal Medical Center Building, P.O. Box 4645, Biloxi, for the practice of peripheral vascular surgery.

Leslie Hammack, formerly of Southaven, has opened up his general practice of medicine in Vardaman.

A. C. Jackson, Jr., has associated with Julian Wiener and Roy A. Kelly, Jr., in the Urology Clinic at 514 E. Woodrow Wilson in Jackson for the practice of pediatric and general urology.

Dewey H. Lane of Pascagoula chaired the Mississippi Economic Council's Goals for Mississippi meeting in Hattiesburg during October. Dr. Lane is 1976-77 president of MEC.

Francis S. Morrison of Jackson and UMC participated in the meetings of the International Society of Hematology and International Hemophilia Association in Kyoto, Japan.

Brantley B. Pace announces the opening of the Medical Clinic at 100 Oak Park in Monticello.

Mario R. Pineda of Jackson announces the relocation of his offices to 1040 N. Flowood Drive for the practice of psychiatry.

Ramesh C. Purohit announces the opening of his office for the practice of surgery and gynecology at 362 Lamar Street in Grenada.

Donald M. Sherline of Jackson and UMC participated in a symposium on intrauterine asphyxia and the developing fetal brain at San Diego.

Walter Treadwell of Jackson is serving as chairman of the special education and fund-raising projects of the Hinds County chapter of the Mississippi Lung Association.

Christmas Seals
Fight Lung Disease



Space contributed by the publisher as a public service

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, June 26-July 1, Dallas. Clinical Convention, Dec. 4-8, 1976, Philadelphia. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

La.-Miss. O. and O. Society, April 28-May 1, 1977, Point Clear, Ala. Arthur Hays, M.D., Secy., 3017 13th St., Gulfport 39501.

STATE AND LOCAL

Mississippi Academy of Family Physicians, Annual Meeting, July 7-10, 1976, and July 6-9, 1977, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 109th Annual Session, May 2-5, 1977, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Smith, Yazoo.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Gerald A. Smith, Secy., P.O. Box 128, Sumner 38957. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. A. K. Martinolich, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Reginald P. White, Secy., East Mississippi State Hospital, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, April, June, August, October, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., Jefferson Davis Memorial Hospital, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. D. Stanley Hartness, Jr., Secy., 314 Adams St., Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Lee H. Rogers, Secy., 610 Brunson Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, October. Cherie Friedman, Secy., 1004 Jackson Ave., Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. James H. Sams, Secy., P.O. Box 1381, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, May, July, September, November. Dewey Laner, Secy., Doctors Plaza, Suite 206, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. John L. Smith, Secy., No. 1 Medical Blvd., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

When the same patient makes your office a merry-go-round of somatic complaints

I don't know how long it's been since I had a restful night's sleep.

My chest feels so tight—I just can't seem to breathe right.

Doctor, if I don't get rid of this pain in my stomach, I'm going to go crazy.



Adapin® (doxepin HCl) may be what she needs

I'm so jumpy, I'm afraid of my own shadow.

I have these headaches almost everyday—I can't understand it, I never used to have them.

Doctor, is it right that I should be so constipated all the time?



Anxiety/depression could be the basis of her somatic complaints
You know the type. She's got a new symptom every visit. And there's never any physiological basis. When you see the chronic "complainer," a diagnosis of depression may be considered . . . and an Rx for Adapin.

Adapin allays anxiety; improves sleep; brightens the outlook
Adapin can often help the chronic "complainers" get positively reinvolved with life. Adapin almost immediately allays symptoms of anxiety and tension. And from the earliest days it makes it easier for the patient to get to sleep—helps her stay asleep longer. And where there is underlying depression, Adapin usually begins to lift it within three or four weeks.

Please see following page for prescribing information

ADAPIN®
(Doxepin HCl)
Capsules, 10 mg, 25 mg and 50 mg

PENNWALT

ADAPIN®
(Doxepin HCl)



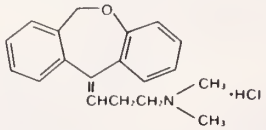
10 mg. **25 mg.** **50 mg.**

Usual optimum dosage is 75 to 150 mg. per day.

Prescribing information:

DESCRIPTION

Adapin (doxepin HCl) is an isomeric mixture of N, N-dimethyl-dibenz(b,e) oxepin- $\Delta^{11(6H)}$, γ propylamine hydrochloride.



ACTIONS

Adapin has a variety of pharmacological actions with its predominant action on the central nervous system. While its mechanism of action is not known, studies have demonstrated that it is neither a monoamine oxidase inhibitor nor a primary stimulant of the central nervous system.

INDICATIONS

In controlled clinical evaluations, **Adapin** has shown marked antianxiety and significant antidepressant effects. **Adapin** has been found to be well tolerated even in elderly patients.

Adapin is indicated for the treatment of patients with:

1. Psychoneurotic anxiety and/or depressive reactions.
2. Mixed symptoms of anxiety and depression.
3. Anxiety and/or depression associated with alcoholism.
4. Anxiety associated with organic disease.
5. Psychotic depressive disorders including involutional depression and manic-depressive reactions.

Target symptoms of psychoneurosis that respond particularly well to **Adapin** include: anxiety, tension, depression, somatic symptoms and concerns, insomnia, guilt, lack of energy, fear, apprehension and worry.

Because **Adapin** provides antidepressant as well as antianxiety effects, it is of particular value in patients in whom anxiety masks depression. Patients who have not responded to other antianxiety or antidepressant drugs may benefit from **Adapin.**

In a large series of patients systematically observed for withdrawal symptoms, none were reported—a finding which is consistent with the virtual absence of euphoria as a side effect and the lack of addictive potential characteristic of this type of chemical compound.

CONTRAINDICATIONS

Because **Adapin** has an anticholinergic effect, it is contraindicated in patients with glaucoma or a tendency toward urinary retention.

Use of **Adapin** is contraindicated in patients who have been found hypersensitive to it.

WARNINGS

Usage in Pregnancy—Adapin has not been evaluated in pregnant patients. Therefore, it should not be used during pregnancy unless, in the judgment of the physician, it is essential to the welfare of the patient.

In animal reproduction studies of **Adapin,** gross and microscopic examination of the offspring gave no evidence of drug-related teratogenic effect. Following doses of up to 25 mg./kg./day for 8 to 9 months, no changes were observed in the number of live births, litter size, or lactation. A decreased rate of conception was observed when male rats were given 25 mg./kg./day for prolonged periods—an effect which has occurred with other psychotropic drugs and has been attributed to drug effect on the central and/or autonomic nervous systems.

Usage in Children—The use of **Adapin** in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors—Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with **Adapin.** The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

PRECAUTIONS

Drowsiness may occur with **Adapin (doxepin HCl);** therefore, patients should be warned of its possible occurrence and cautioned against driving a motor vehicle or operating hazardous machinery while taking the drug.

Patients should also be cautioned that the effects of alcoholic beverages may be increased.

Since suicide is an inherent risk in depressed patients and remains a risk through the initial phases of improvement, depressed patients should be closely supervised.

Although **Adapin** has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Compounds structurally related to **Adapin** can block the effects of guanethidine and similarly acting compounds. However, at the usual clinical dosages, 75 mg. to 150 mg. per day, **Adapin** has been given concomitantly with guanethidine without blocking its antihypertensive effect. But at dosages of 300 mg. per day or higher, **Adapin** has exerted a significant blocking effect.

Adapin, like other structurally related psychotropic drugs, potentiates norepinephrine response in animals. But this effect has not been observed with **Adapin** in humans, which is in accord with the low incidence of tachycardia reported clinically.

ADVERSE REACTIONS

Anticholinergic Effects: Dry mouth, blurred vision and constipation have been reported. These are usually mild, and often subside as therapy is continued or dosage reduced.

Central Nervous System Effects: Drowsiness has been observed. It usually occurs early in the course of therapy and tends to subside as therapy continues. (See Dosage and Administration section.)

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported adverse effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects (such as increased sweating), weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

DOSAGE AND ADMINISTRATION

In most patients with mild to moderate anxiety and/or depression: 10 mg. to 25 mg. t.i.d. to start. A starting dosage of 10 mg. t.i.d. for a period of four days may reduce the initial drowsiness experienced by some patients, and may be tried in cases where drowsiness is clinically undesirable. Decrease or increase the dosage at appropriate intervals according to individual response. Usual optimum dosage is 75 mg. to 150 mg. per day.

In some patients with mild symptomatology or emotional symptoms accompanying organic disease, dosage as low as 25 mg. to 50 mg. per day has provided effective control.

In more severe anxiety and/or depression: 50 mg. t.i.d. may be required to start—if necessary, gradually increase to 300 mg. per day. Additional effectiveness is rarely obtained by exceeding 300 mg. per day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

OVERDOSAGE

Symptoms—An increase of any of the reported adverse reactions, primarily excessive sedation and anticholinergic effects such as blurred vision and dry mouth. Other effects may be: pronounced tachycardia, hypotension and extrapyramidal symptoms.

Treatment—Essentially symptomatic; supportive therapy in the case of hypotension and excessive sedation.

HOW SUPPLIED

Each capsule contains doxepin, as the hydrochloride: 10 mg. (NDC 0018-0356), 25 mg. (NDC 0018-0357) and 50 mg. (NDC 0018-0358) capsules in bottles of 100, and 1000.

Brighter days ahead for your psychosomatic complainers



PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603

The Mississippi Public Health Association Holds 39th Annual Meeting in Jackson

Governor Cliff Finch gave the keynote address at the 39th annual meeting of the Mississippi Public Health Association at the Holiday Inn Downtown in Jackson, Sept. 15-17.

Gov. Finch defended his choice of the Mississippi Health Systems Agency as the state health planning agency by saying he believed the MHSA will carry service to even the smallest rural communities.

The governor admitted that the federal government may have overextended itself with recent health legislation but added that as governor he intends to follow the law.

Mississippi Congressman David R. Bowen also addressed the group and discussed new public health directions and the national outlook.

Public Health Service Awards were made by State Health Officer, Dr. Alton B. Cobb, and MPHA president, Joe Cone.

Bolivar County Health Officer Dominic Tumminello was awarded the Felix J. Underwood Award for his "outstanding contributions and achievements" in the field of public health. Dr. Tumminello joined the Bolivar County Health Department in 1942.

Among his achievements there are a 1949 syphilis survey and treatment campaign which received national recognition. And in 1956, Bolivar County Health Department was the first official agency to give home treatment to people with tuberculosis.

Sections on Administration, Public Health Nursing, Clerical Workers, Community Health Services, Sanitation, and Epidemiology met during the week and heard guest speakers from Atlanta, Chapel Hill, NC, Spartanburg, SC, and Memphis.

Dr. Frank M. Wiygul of Jackson was inaugurated president of the group. Other new officers are: president-elect, Frankie Smith; administrative section chairman, Mike Henner; public health nursing section chairman, Marguerite Quarles; clerical section chairman, Marguerite Bacon; community health services section, Ann Plummer; sanitation and environmental section chairman, Homer Smith; and epidemiology section chairman, Tucker Brown.



Dr. Dominic Tuminello, Bolivar County health officer, receives congratulations from his wife, Frances, and Congressman David Bowen after receiving the Felix J. Underwood Award for outstanding contribution to the field of public health. The award is the highest given by the Mississippi Public Health Association.

UMC Continues Record Enrollment

A total of 150 medical students enrolled in the University of Mississippi School of Medicine this fall continuing the record enrollment of freshmen students begun last year.

Nationally, a total of 57,236 medical students were enrolled in 116 medical schools across the country this fall, including 15,349 first year students—a record number.

UMC figures reveal a total of 565 medical students in school this fall, up some 65 per cent over enrollment five years ago when 366 medical students were attending UMC. Women students number 104 or some 18 per cent of total enrollment. Minority students number 47 or some 8 per cent of total enrollment. Five years ago there were 28 women students and 11 minority students enrolled.

Juvenile Diabetes Board Is Announced

The Greater Jackson Chapter of the Juvenile Diabetes Foundation has announced its Medical Advisory Board, composed of Jackson physicians who have a special interest in diabetes. They will advise the local chapter in its educational program, its counseling services to diabetics and their families, and in its primary purpose of funding research which will ultimately develop a cure as well as ways to stop the complications of diabetes.

Serving as chairman of the Medical Advisory Board is Dr. Karleen Neill, associate professor, department of medicine, hypertension and diabetes clinic number five, University Medical Center.

Other members are Drs. William F. Sistrunk, Robert L. Abney III, Jim G. Hendrick, Weir Conner, Noel C. Womack, Jr., Erwyn E. Freeman, Jr., and Paul F. Welch of the Children's Medical Group, P. A.;

Howard Nichols, Joseph E. Miller, Robert H. Thompson, Jr., Joe Donaldson and Glen Graves of the Children's Clinic;

Dale C. Read, J. Manning Hudson, Robert E. Tyson, David J. Vanlandingham, G. Boyd Shaw, T. E. Wilson III, and G. C. Stubblefield of Jackson Medical Associates;

Jeanne R. Bonar, assistant professor, division of endocrinology, J. M. Montalvo, professor of pediatrics and assistant professor of biochemistry, Division of Endocrinology and Metabolism;

Raul E. Valenzuela, professor of ophthalmology, diseases and surgery of the retina, all of UMC; James Keeton, pediatric urology, St. Dominic's Medical Offices;

Eric A. McVey, Jr., director, Hinds County Health Department; and Glenda Scallorn, assistant professor, Department of Psychiatry and Human Behavior, UMC.

Insulin-dependent diabetics of all ages and their families who wish to learn more about the Juvenile Diabetes Foundation may write to The Greater Jackson Chapter, Juvenile Diabetes Foundation, 1222 Greenbriar, Jackson, MS 39211.

Medical Center Gains Faculty Members

Two assistant professors and an instructor have been appointed to the University of Mississippi School of Medicine faculty.

Dr. Norman Anthony Moore will join the teaching staff in December as an assistant professor of anatomy, and Dr. Edward F. Meydrech will come to the Medical Center in January as an assistant professor of preventive medicine (biostatistics).

Dr. Stephen Hall Randall joined the medical school faculty September 1 as an instructor in pathology.

UMC Vice Chancellor Dr. Norman C. Nelson announced the appointments on approval of the Board of Trustees of Institutions of Higher Learning.

Dr. Randall, a 1973 graduate of the Mississippi medical school who did a two-year residency at University Hospital, returned after a year as registrar in pathology at the University of Glasgow, Scotland. He holds the B.S. degree from Millsaps College.

Dr. Moore is currently an assistant professor of anatomy at the University of South Florida College of Medicine, Tampa. On the South Florida faculty since 1971, he did undergraduate work at Midwestern State University, Wichita Falls, TX, and earned the Ph.D. degree at the University of Texas Medical Branch at Galveston.

An assistant professor at Virginia Commonwealth University, Richmond, since 1972, Dr. Meydrech got his Ph.D. degree at the University of North Carolina at Chapel Hill. He also has bachelor's and master's degrees from the University of Florida at Gainesville.

HSAs Board Composition Disclosed

A recent survey of some 136 Health Systems Agencies around the country reveals that consumers hold 52 per cent of the seats on governing boards of HSAs and providers hold 48 per cent of the seats.

Under requirements of Public Law 93-641 HSA governing boards must have a majority of consumers and providers must compose at least 40 per cent of the board's membership.

Men hold nearly 75 per cent of the HSA governing body seats. Minority group members make up 24 per cent of the total consumers on the HSA governing bodies.

In Mississippi, the 30 member governing board of the Mississippi Health Systems Agency, Inc. has a provider/consumer membership percentage of 47/53 respectively. Men comprise 63 per cent of the governing board membership and minority group members make up 50 per cent of the total consumers on the board.

UMC Researcher Studies Immunotherapy Protocols

A University of Mississippi Medical Center investigator is researching immunotherapy protocols for cancer treatment with grant support from the National Institutes of Health National Cancer Institute ($127,500 for three years) and the American Cancer Society ($80,000 for two years).

Using a hamster strain which is highly susceptible to tumor growth from the SV40 virus, Dr. John Blasecki, assistant professor of microbiology, will try several intervention methods to allow the animals to mount an immune response to the virus.

Dr. Blasecki injects the virus into the hamsters before they are 24 hours old, during the time when the immune response system has not yet matured. Because he is working with the susceptible strain, nearly all the animals will develop tumors in three to four months.

The latent period, from day 25 after inoculation until day 40, has been described in previous research. During this two week period, the immunotherapy protocols can affect the animal's immune response system.

The UMC scientist holds the most hope for the enzyme treatment of lymphocytes, rendered powerless by the blocking factors in a tumor-bearing animal.

Lymphocytes from tumor-bearing hamsters will be removed and treated with a proteolytic enzyme such as trypsin or papain which removes the blocking factors from the cell membrane.

The unblocked lymphocytes will then be injected into hamsters during the two week latent period. From Dr. Blasecki's previous research, he believes the protocol will prevent tumorigenesis in the hamster.

In another study, the enzyme treated lymphocytes prevented the formation of a tumor in mice even when combined with tumor cells.

He also believes the use of the "re-armed" lymphocytes holds the most potential for clinical application.

In clinical use, after a tumor has been surgically excised, the patient's own lymphocytes could possibly be removed and treated, then injected back into the blood stream to attack remaining tumor cells and prevent metastasis.

The American Cancer Society grant will support Dr. Blasecki's further studies on the nature of the lymphocytes and their exact role in tumor regression.

He wants to find out which kinds of lymphocytes are most important in killing tumor cells—those originating in the thymus which are active in cell mediated immunity, the lymphocytes produced in the bone marrow which makes antibodies, or the nonspecific macrophages.

By inhibiting each type of the lymphocytes in turn, Dr. Blasecki wants to pinpoint which type or types must be blocked to allow tumor growth.

Care of Acutely Injured Is Studied

"Recent Advances in Care of the Acutely Injured," a seminar for surgeons and residents, will be held Jan. 24-26, 1977, at the Fairmont Hotel in New Orleans.

The course is sponsored by the American College of Surgeons Committee on Trauma, and co-sponsored by the Department of Surgery, Tulane Medical Center, New Orleans. Course director is Dr. Martin S. Litwin of Tulane Medical Center.

The seminar has a limited registration of 200. The fee for surgeons is $200; for residents, $100. Advance registration forms may be obtained by writing either the American College of Surgeons, Trauma Division, 55 East Erie, Chicago, IL 60611, or Dr. Litwin at 1430 Tulane Avenue, New Orleans, LA 70112.

UMC Hosts Genetics Workshop



Physicians from three states gathered at the University of Mississippi Medical Center this fall for a two-day update on medical genetics. Faculty included, from left, Dr. Sara C. Finley, co-director of the medical genetics lab and professor of pediatrics at the University of Alabama in Birmingham; Dr. John F. Jackson, UMC professor of preventive medicine and workshop coordinator; Dr. Wayne C. Finley, director of the Alabama medical genetics lab and professor of pediatrics; and Dr. Donald M. Sherline, UMC professor of obstetrics-gynecology. The Mississippi medical school preventive medicine department and Medical Center Division of Continuing Health Professional Education sponsored the course with support from the National Foundation—March of Dimes and Mississippi Regional Medical Program.

Guyton Loan Fund Trustees Meet

The Board of Trustees of the Dr. Billy S. Guyton Memorial Medical Education Loan Fund recently met and allocated twenty $500 loans to assist medical students at the University of Mississippi School of Medicine. Medical education loan grants have now been extended to 100 medical students since the memorial fund was started in 1971.

The Guyton Memorial Medical Education Loan Fund was established in memory of Dr. Billy S. Guyton, dean of the Ole Miss School of Medicine at Oxford and Mississippi medical leader who died in 1971. The fund is sponsored by the University of Mississippi School of Medicine, the Medical Alumni Chapter of the University of Mississippi Alumni Association and MSMA.

Dr. Lyne S. Gamble, MSMA president, and Dr. Charles Farris, medical alumni president, serve as co-chairmen of the Board of Trustees of the Guyton Memorial Fund. Also serving on the Board are Drs. Paul H. Moore, Pascagoula; Faser Triplett, Jackson; Carl G. Evers, Jackson; L. Stacy Davidson, Jr., Cleveland; John M. McRae, Jr., Laurel and Wayne P. Cockrell, Magee.

Ole Miss Pot Is Good Stuff

Ole Miss which is well known for its exploits on the gridiron has recently received front page attention in the *Washington Post* noting the excellence of its marijuana crop.

In a recent edition the *Post* describes the five acre crop of marijuana being grown at Ole Miss with federal approval and quotes an expert as describing the crop as "good stuff." The Ole Miss product, instead of being hand-rolled into scraggly "joints," is packaged into cigarettes containing one gram each of marijuana and into capsules containing THC, the active ingredient of marijuana.

The Ole Miss marijuana is used in federally approved research projects. One of the projects described in the *Post* article will involve using the drug to treat "open angle" glaucoma, a type of glaucoma where surgery is performed only as a last resort. The ultimate goal of the marijuana glaucoma project is to develop an eye drop that is more effective in relieving eye pressure than present drugs.

Physicians Urge Nursing Home Improvements

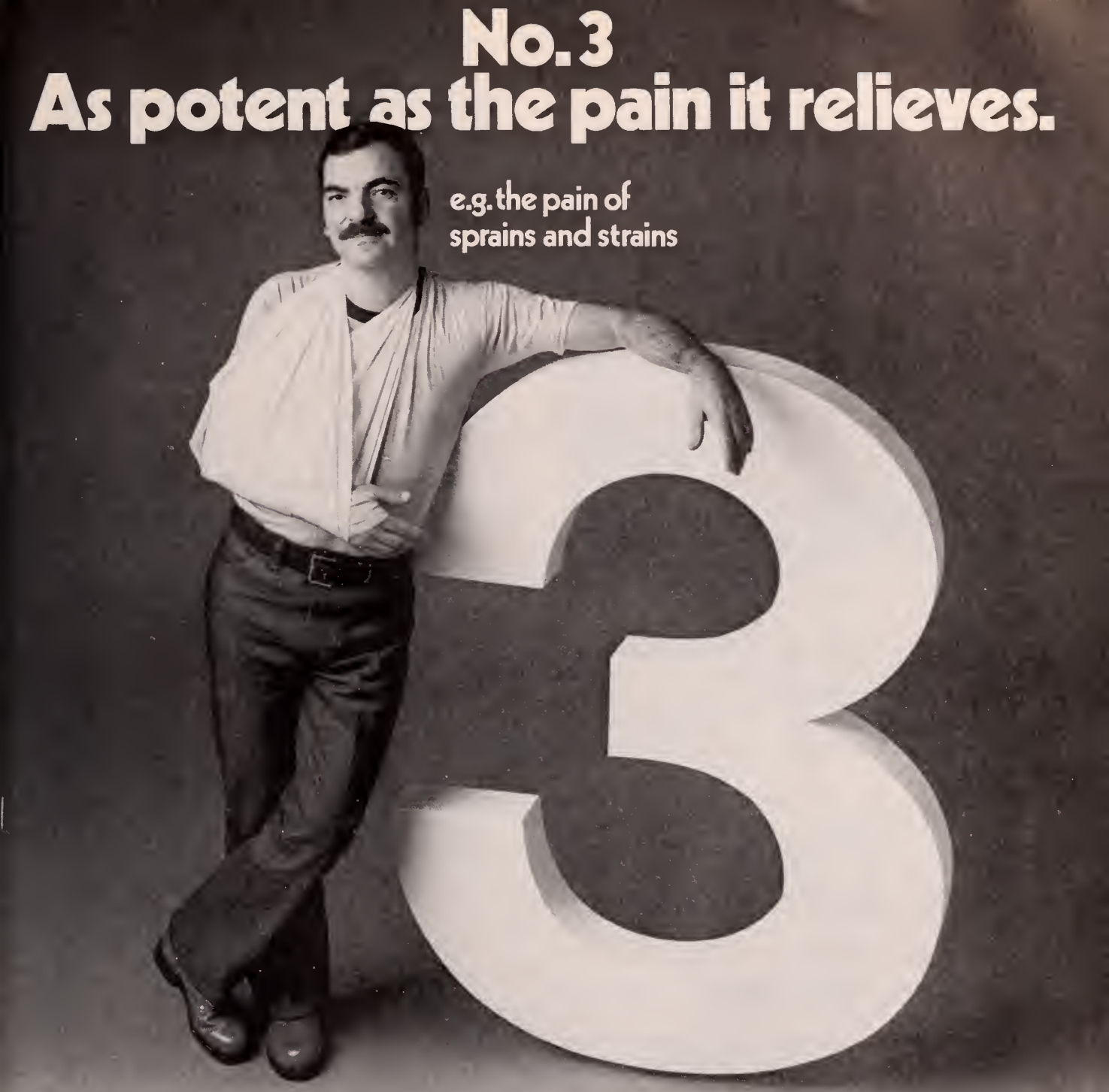
The quality of medical care provided in American nursing homes is good, but it could be better.

This is the finding of a poll of 850 physicians whose practices deal with older patients, published in the Impact section of American Medical News.

The doctors polled were those who indicate a primary, secondary or tertiary specialty interest in geriatrics, the medical specialty dealing with older people.

Underscoring some deficiencies in the nursing homes themselves and in the funding of care for these patients, the majority of physicians responding to the poll admitted that many doctors generally have shunned their responsibilities to nursing home patients.

No. 3
As potent as the pain it relieves.



NOT TOO LITTLE

- as potent as the pain you need to relieve in patients with fractures, sprains, strains, wounds, contusions, and the pain of surgical convalescence
- unlike acetaminophen/codeine combinations, it does not sacrifice anti-inflammatory action

NOT TOO MUCH

- potent—yet not excessive
- addiction liability low

NOT TOO EXPENSIVE

- brand-name quality, yet reasonable in cost
- readily available in both hospital and local pharmacies

CONVENIENCE

- telephone Rx in most states, up to 5 refills in 6 months at your discretion (where state law permits)

EMPIRIN® COMPOUND WITH CODEINE NO. 3

codeine phosphate* (32.4 mg) gr ½
Each tablet also contains: aspirin gr 3½, phenacetin gr 2½, caffeine gr ½. *Warning–may be habit-forming

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Quality of medical care in nursing homes is rated good to excellent by 76 per cent of the respondents, while 21 per cent say it is only fair and 4 per cent say poor. The leading criticism of nursing homes voiced by the doctors is lack of adequate medical personnel, followed by lack of adequate medical supervision, shortcomings in the physical plant and amenities, and poor attitude on the part of employees.

Network for Continuing Medical Education

PROGRAM SCHEDULE

Nov. 1, 1976 through Nov. 14, 1976

"HYPERTENSIVE RETINOPATHY: FUNDUSCOPIC FEATURES," with Richard E. Goldberg, M.D., director, and Larry E. Mafiargal, M.D., co-director, Retinal Vascular Unit, Wills Eye Hospital, Philadelphia.

"LACTIC ACIDOSIS: PATHOGENESIS & ETIOLOGY," with Philip Felig, M.D., professor and vice-chairman, Department of Internal Medicine, and chief, Endocrinology Section, Yale-New Haven Hospital and Yale University School of Medicine, New Haven.

"LACTIC ACIDOSIS: DIFFERENTIAL DIAGNOSIS & TREATMENT," with Philip Felig, M.D., professor and vice-chairman, Department of Internal Medicine, and chief, Endocrinology Section, Yale-New Haven Hospital and Yale University School of Medicine, New Haven.

Nov. 15, 1976 through Nov. 28, 1976

"FIBEROPTIC BRONCHOSCOPY: ITS USES AND ADVANTAGES," with Bernard Marsh, M.D., associate professor of otolaryngology, Johns Hopkins University School of Medicine, and director, Broyles Bronchoscopic Clinic, Johns Hopkins Hospital, Baltimore, Md.

"ALCOHOL INGESTION: ACUTE METABOLIC SYNDROMES," with Philip Felig, M.D., professor and vice-chairman, Department of Internal Medicine, and chief, Endocrinology Section, Yale-New Haven Hospital and Yale University School of Medicine, New Haven.

"CAT SCANNING: A NEW DIMENSION," with John R. Haaga, M.D., radiologist, Department of Radiology, The Cleveland Clinic, Cleveland, Ohio.

Nov. 29, 1976 through Dec. 12, 1976

"THE SELECTIVE USE OF RADIOGRAPHS AND LABORATORY TESTS IN RHEUMATIC DISEASE," with Rodney Bluestone, M.B., M.R.C.P., chief, Rheumatology Section, Wadsworth VA Hospital, Los Angeles; and professor of medicine, UCLA School of Medicine, Los Angeles.

"THE FUNCTION OF PHAGOCYTES," with Thomas P. Stassel, M.D., chief of the Medical Oncology Unit at Massachusetts General Hospital and associate professor of medicine at Harvard Medical School in Boston, MA.

"BACTERIAL INFECTION AND DISORDERS OF THE WHITE CELL," with Thomas P. Stassel, M.D., chief of the Medical Oncology Unit at Massachusetts General Hospital and associate professor of medicine at Harvard Medical School in Boston, MA.

Dec. 13, 1976 through Dec. 26, 1976

"CARDIAC REHABILITATION: A STATUS REPORT," with Elliott M. Stein, M.D., assistant professor of medicine, New Jersey College of Medicine and Dentistry, and chief of the Exercise Laboratory and the Cardiac Rehabilitation Program, Saint Michael's Medical Center, Newark, NJ.

"HOW TO ASSESS THE WHIPLASH INJURY," with John E. Stewart, M.D., clinical professor of orthopedic surgery, University of Washington School of Medicine, Seattle, WA.

Vascular Surgery Course Planned

"VASCULAR SURGERY—UPDATED" will be held Feb. 3-5, 1977, at Ochsner Medical Institutions Monroe Hall, New Orleans. Program director is John L. Ochsner, M.D.

This course is directed toward the practicing general and vascular surgeon and its purpose is to update the practicing surgeon as to the newer developments in vascular surgery. There are to be short, formal lectures and panel discussions with questions from the audience. There will also be some wet clinics to demonstrate the operative technic of certain procedures. Registration fee is $125.00.

Please send all requests for information to: Continuing Education, Alton Ochsner Medical Foundation, 1516 Jefferson Highway, New Orleans, LA 70121, 504/834-7070, Ext. 5831.

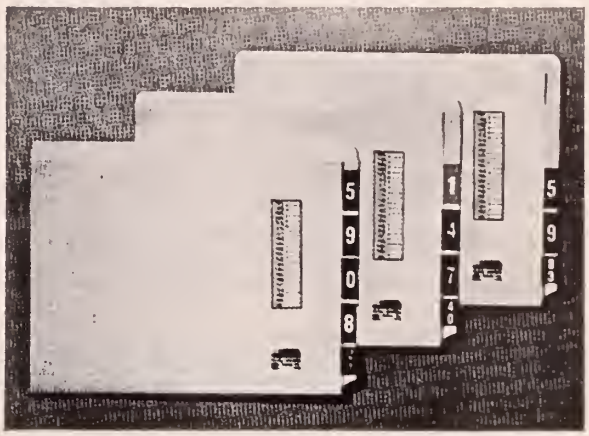
CLASSIFIED

TAX DEDUCTIBLE VACATIONS FOR MEDICAL PROFESSIONALS. Over 500 listings of national/international meetings in the medical sciences for 1977. Send a $10 check or money order payable to Professional Calendars, P.O. Box 40083, Washington, D.C. 20016.

JOIN MPAC TODAY

WHY OUR COLOR CODED FILING SYSTEM?

REDUCES FILING TIME
ELIMINATES MIS-FILES
NO NEED TO REPLACE YOUR PRESENT FOLDERS



PRINTING — OFFICE DESIGN, FURNITURE & SUPPLIES

Mississippi Stationery Company

277 East Pearl Street — Jackson, Mississippi 39201

FOR MORE INFORMATION
CALL COLLECT (601) 354-3436

Index to Advertisers

Beltone Electronics Corp. 7
Burroughs Wellcome Co. 345

Canton Exchange Bank 11
Coca-Cola 11

Hill Crest Hospital 8
Humana, Inc. 10
Hyrex-Key Pharmaceuticals 6

Eli Lilly and Co. front cover

Mallinckrodt, Inc. 10A
Mead Johnson Laboratories 12
Miss. Stationery Co. 19

Pennwalt Prescription Products 340B, 340C, 340D
Pharmaceutical Manufacturers Assoc. 16, 17
Premier Printing Co. 10
Professional Calendars 19

Riverside Hospital 18
Roche Laboratories second cover, 3, 14, 14A, third and fourth covers
Roerig and Co. 14B, 338, 339

Smith Kline and French 332A

The Upjohn Co. 332B, 332C, 332D

Thomas Yates and Co. 4

IN CONCLUSION

Medicare carriers are closely monitoring claims submitted by physicians for laboratory services when the source of the services is not identified. Carriers are required to determine the source of lab services in order to (1) determine that the lab is certified by Medicare, and (2) determine the appropriate payment to cover the lab's customary charge. Physicians are urged to fully disclose the source of tests for which payment is claimed under the Medicare program, says the October 1976 Tennessee Medical Association Newsletter.

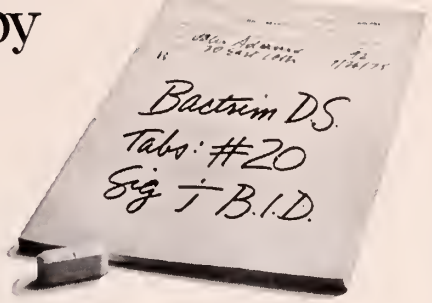
A more active role by practicing physicians in the affairs of blood banking and blood uses is a major concern of the AMA's Committee on Transfusion and Transplantation and is the basis for a new AMA publication, "Guide for Hospital Committees on Transfusions." Pamphlet outlines the organization and membership of a hospital transfusion committee. Suggested activities of the committee and a section on blood banking facilities and services under Medicare are included. Pamphlets -OP 87- cost 40¢ each from Order Dept., AMA.

Federal taxes for the average worker supporting a family of four went up 23.4 per cent in the past 12 months, the Labor Department reports. Average worker was paying $16 a week -- 9.6 per cent of gross pay -- for Social Security and federal income taxes in August 1975, the dept. said. In August 1976 the same worker's federal tax withholding amounted to $20 a week, or 11.2 per cent of total pay. Beginning January 1, Social Security will raise ceiling on earnings subject to tax from $15,300 to $16,500. Maximum SSA tax on self-employed rises to $1,303.50.

Alcoholism counseling by the surgical staff has been made an integral part of postoperative regimen for cirrhotic patients which also includes diet, medication, monitoring and tests, at the Portal Hypertension Clinic at the University of California, San Diego. Program participants believe the interaction between the doctor and the patient is more effective in preventing a resumption of drinking than conventional rehabilitation methods. They say the shared relationship between surgeon and patient in a life-saving situation cannot be duplicated.

Miscellaneous: HMO bill was signed by the president. New law relaxes federal requirements for establishing and operating HMOs. Most significant provision eliminates previous requirement that all HMOs have "open enrollment" periods. Law also allows private physicians, under certain conditions, to work part-time for HMOs... Based on official action by the Tennessee Medical Association House of Delegates, Medicare will no longer recognize several fee areas in that state. Physicians' services will now be reimbursed according to statewide fee profiles.

10-day Bactrim therapy outperforms 10-day ampicillin therapy.



In a multicenter, double-blind study of patients with chronic or frequently recurrent urinary tract infection, Bactrim 10-day therapy outperformed ampicillin 10-day therapy by 27.2%, when comparing patients who maintained clear cultures for eight weeks. Criterion for "clear culture" was 1000 or fewer organisms/ml of urine.

While adverse reactions noted in this study were mild (*e.g.*, vomiting, nausea, rash), more serious reactions can occur with these drugs. See manufacturer's product information for complete listing. Maintain adequate fluid intake; perform frequent CBC's and urinalyses with microscopic examination.

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

Bactrim™ DS
(160 mg trimethoprim and 800 mg sulfamethoxazole)
Double Strength tablets
Just 1 tablet B.I.D.

Bactrim™

(80 mg trimethoprim and 400 mg sulfamethoxazole)
2 tablets B.I.D.

For chronic or frequently recurrent cystitis and pyelonephritis due to susceptible organisms.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections evidenced by persistent bacteriuria (symptomatic or asymptomatic), frequently recurrent infections (relapse or reinfection), or infections associated with urinary tract complications, such as obstruction. Primarily for cystitis, pyelonephritis or pyelitis due to susceptible strains of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris* and *Proteus morganii.*

NOTE: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections. The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. **Data are insufficient to recommend use in infants and children under 12.**

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) every 24 hours
Below 15	Use not recommended

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole — bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

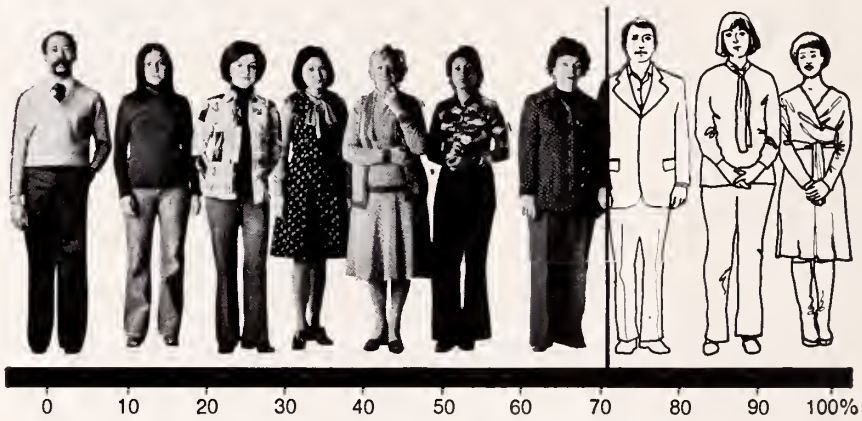
Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; fruit-licorice flavored — bottles of 16 oz (1 pint).

ROCHE

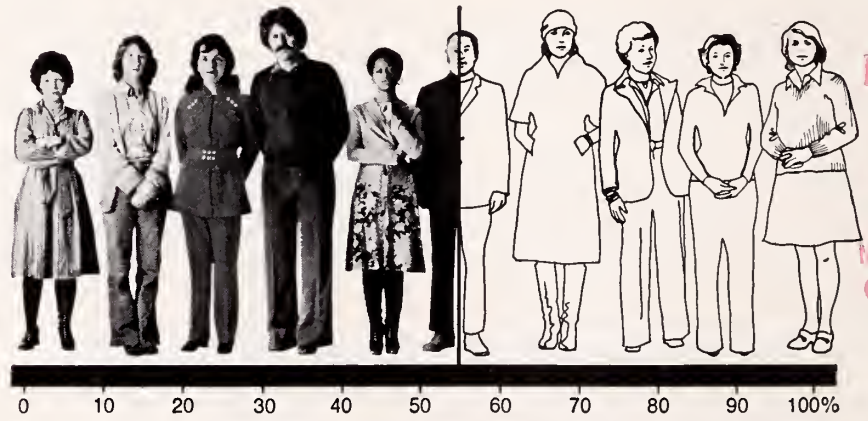
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

In a multicenter study of patients with chronic or frequently recurrent urinary tract infections

Bactrim was 27.2%* more effective than ampicillin in keeping patients infection-free for 8 weeks.†



Bactrim–70.5% of 78 patients infection-free at 8 weeks.



ampicillin–55.4% of 74 patients infection-free at 8 weeks.

*This percentage is arrived at by the statistical method of dividing the difference between Bactrim and ampicillin results (15.1%) by the percent of ampicillin results (55.4%).

†Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110

Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

Double Strength tablets Just 1 tablet B.I.D.

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

Please see summary of product information on preceding page.

ROCHE

2EAST 103RD ST
NEW YORK N.Y.
10029

LIBRARY
NOV 15 1976
NEW YORK ACADEMY
OF MEDICINE

BALCONY

AMERICAN REVOLUTION BICENTENNIAL 1776-1976

JOURNAL OF THE Mississippi STATE MEDICAL ASSOCIATION

DECEMBER 1976

From Lilly/Dista Research

NALFON®
fenoprofen calcium

300-mg.* Pulvules®

DISTA
Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

Additional information available to the profession on request.

*Present as 345.9 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. fenoprofen.

600120

This Month . . . Blastomycosis, Histological Examination of Skin Cancers, General Radiology

M.S.M.A.

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) Ⓥ

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Surgeons' Practice Habits Surveyed

A Harvard Medical School national survey has revealed that the average American surgeon performs 170 operations per year and that more than two-thirds of the surgeon's total professional care was spent in *direct* patient care. The findings, drawn from a survey of medical and osteopathic physicians performing surgery in the course of their practice, also revealed:

—that the average American surgeon works 46 hours a week.

—that he has income before taxes of $45,700.

—that half of the surgeon's time was spent in the hospital, with 20 per cent of that relegated to the operating room.

—that paperwork was not a major item for surgeons, with an average of 5.7 hours per week spent on practice administration.

Median income for surgeons was 20 per cent above the median income for all other physicians.

The data was collected by a committee entitled Study on Surgical Services for the United States (SOSSUS), a joint creation of the American College of Surgeons and the American Surgical Association.

Survey Shows NHI Support

A recent survey by the Princeton based Opinion Research Corporation has found that by a majority of two to one, Americans say they favor a national health insurance program.

Most of the respondents also felt that any national health insurance program should be administered by private industry rather than government.

The survey also found that 61 per cent of the respondents felt that government spending was the number one cause of inflation.

Is there a tablet containing *only* an expectorant and *only* Glyceryl Guaiacolate? YES!

1. Patient acceptable tablet dose.
2. Single entity expectorant.
3. Measured tablet dose.
4. Sugar-free tablet.

An identifiable white, scored tablet which significantly stimulates the secretion of respiratory tract fluid.

HYTUSS TABS

(GLYCERYL GUAIACOLATE 100mg.)





Composition: Each sugar-free compressed tablet contains glyceryl guaiacolate 100mg. **Action and Use:** This preparation utilizes the effective expectorant action of glyceryl guaiacolate which significantly stimulates the secretion of respiratory tract fluid. The increased flow of less viscid fluid favors expectoration and has a demulcent effect on the tracheobronchial mucosa. The primary usefulness of Hytuss Tabs is to promote the change from a dry, unproductive cough to a productive cough. Hytuss is therefore useful in treating coughs due to the common cold, bronchitis, laryngitis, tracheitis, pharyngitis, influenza and the measles. The expectorant action of Hytuss may also provide symptomatic relief in some chronic respiratory disorders when the patient experiences spasms of dry nonproductive coughing. **Precautions:** Extremely large amounts may cause nausea and vomiting. **Administration and Dosage:** *Adults*—1 tablet four times daily. *Children*—6 to 12 years of age; ½ tablet 3 or 4 times daily. HOW SUPPLIED: White, scored, sugar-free, tablet in bottles of 100 - 1,000 - 5,000. **Product Identification Mark:** Hy. **Literature Available:** On request.

Available through all drug wholesalers.

Hyrex

HYREX COMPANY

832 South Cooper
Memphis, Tenn. 38104

Volume XVII
Number 12
December 1976



JOURNAL of the Mississippi
STATE MEDICAL ASSOCIATION

• EDITOR
W. Moncure Dabney, M.D.

• ASSOCIATE EDITORS
George H. Martin, M.D.
Myron W. Lockey, M.D.

• MANAGING EDITOR
Nola Gibson

• PUBLICATIONS COMMITTEE
Lawrence W. Long, M.D.
Chairman
Robert R. McGee, M.D.
T. A. Baines, M.D.
and the editors

• THE ASSOCIATION
Lyne S. Gamble, M.D.
President
James O. Gilmore, M.D.
President-Elect
J. Elmer Nix, M.D.
Secretary-Treasurer
C. D. Taylor, Jr., M.D.
Speaker
R. Faser Triplett, M.D.
Vice Speaker
Charles L. Mathews
Executive Secretary
H. Cody Harrell
Assistant Executive Secretary
William F. Roberts
Legal Counsel

The Journal of the Mississippi State Medical Association is owned and published monthly by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, $15.00 per annum; $2 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

CONTENTS

ORIGINAL SCIENTIFIC PAPERS

The Recognition and Management of Blastomycosis **347** George E. McGee, Hamp D. Williams, and Guy D. Campbell, M.D., Jackson, MS

Complete Histological Examination of Excised Skin Cancers for Adequacy of Excision **351** Jim M. Brock, M.D., McComb, MS

SPECIAL ARTICLE

Radiologic Seminar CLXV: The Passing of the General Radiologist **355** Robert D. Sloan, M.D., Jackson, MS

EDITORIAL

The New President and Medicine **359** W. Moncure Dabney, M.D., Crystal Springs, MS

THIS MONTH

The President Speaking **358** "Legislation in 1977"

Auxiliary Page **363** Mrs. W. A. Brown, Jr., Mathiston, MS

Medical Organization **365** Executive Director Phil Laird Reports on MS Health Systems Agency

Index for Volume XVII **367** January-December 1976

Copyright 1976, Mississippi State Medical Association

Cardiac Symposium Set for Arizona

The American Heart Association, Arizona affiliate, will sponsor its 20th annual cardiac symposium at Mountain Shadows Resort Hotel, Scottsdale, on Jan. 21-22, 1977. The speakers will include Drs. H. J. C. Marriott, W. Proctor Harvey, William Roberts and Gerald D. Buckberg.

Registration fee for two days, including lunches, will be $60 (one day—$35). Deadline for hotel accommodations is Dec. 21, 1976. Deadline for symposium registration is Jan. 14, 1977.

Twelve hours of postgraduate credit has been applied for through the American Academy of Family Physicians and the Arizona Medical Association.

Further information may be obtained from the American Heart Association, Arizona affiliate, 1445 East Thomas Road, Phoenix, AR 85014, or by telephone to (602) 277-4846.

Laetrile Use Is Boosted

The government's powers to move against quack remedies suffered a setback when a Federal Appeals Court in Denver, Colorado, recently refused to overturn a District Court decision allowing a cancer patient to buy and transport the questionable anti-cancer product, Laetrile.

The Appeals Court did not rule on the question of whether Laetrile was effective or whether the Food and Drug Administration had the right to bar it from the market. The FDA record on Laetrile was "grossly inadequate," the court said. "The question whether this is a new drug presents a mixed question of fact and law which should be fully tried," said the Appeals Court. The FDA was ordered to "develop a record supportive of the agency's determination."

The FDA had no immediate comment on the decision. Staff lawyers were unsure how to proceed. However, the Appeals Court muddied the waters on the legal status of the controversial drug which has served as a focus for complaints that FDA is overstepping its authority in cracking down on non-authorized drugs or products.

An Oklahoma City District Court judge had ruled earlier that Laetrile was effective and that the FDA was acting unconstitutionally in seeking to prohibit it.

for the inflamed phase of hemorrhoidal flare-up

ANUSOL-HC® SUPPOSITORIES
Rectal Suppositories with Hydrocortisone Acetate

ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate

CAUTION: Federal law prohibits dispensing Anusol-HC Suppositories and Anusol-HC Cream without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian Balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: bismuth subiodide, calcium phosphate, and coloring in a bland hydrogenated oil-cocoa butter base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg, benzyl benzoate, 12.0 mg; Peruvian Balsam, 18.0 mg, zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, bismuth subiodide, propylparaben, methylparaben, polysorbate 60, sorbitan monostearate in a water-miscible base of mineral oil and glyceryl monostearate. Non-staining.

Indications: Anusol-HC is adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis and fissures, incomplete fistulas, and relief of local pain following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. When acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: History of sensitivity to any component. Topical corticosteroids should not be employed in tuberculous, fungal and most viral lesions of the skin (including herpes, vaccinia and varicella).

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy they should not be used unnecessarily on extended areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment. When there is bacterial skin infection, topical corticosteroids should be used only with appropriate concomitant antimicrobial therapy. Prolonged or excessive use of corticosteroids might produce systemic effects.

Dosage and Administration: Anusol-HC Suppositories: Remove foil wrapper and insert into the anus. One suppository in the morning and one at bedtime, for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol.

Anusol-HC Cream: Adults—Remove tube cap and attach the plastic applicator. After gentle bathing and drying of the area, apply to the exterior surface and gently rub in. For internal use, insert the applicator by applying gentle, continuous pressure. Then squeeze tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol.

Supplied: Anusol-HC Suppositories—boxes of 12 (N 0047-0089-12) suppositories in silver foil strips with (WC) printed in black.

Anusol-HC Cream—one-ounce tube (N 0047-0090-01) with plastic applicator; detachable label.

Full information is available on request.

Warner/Chilcott
Division,
Warner-Lambert Company,
Morris Plains,
New Jersey 07950

AN-GP-51-4C

THE PROFESSIONAL SOURCE OF

COMFORT

FOR INTERNAL & EXTERNAL ANORECTAL CONDITIONS

Anusol-HC®

suppositories and cream
with hydrocortisone acetate. Rx only

pain and burning respond in minutes

- without belladonna alkaloids
- without CNS stimulants



Artist's interpretation in bas-relief of external hemorrhoids, postoperative anorectal wounds and anal dermatitis.

Famous Fighters



NEOSPORIN® Ointment
(polymyxin B-bacitracin-neomycin)
is a famous fighter, too.

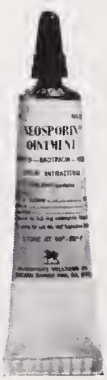
Provides overlapping, broad-spectrum antibacterial action to help combat infection caused by common susceptible pathogens (including staph and strep).

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Society of Contemporary Ophthalmology Meets

A joint meeting of the American Society of Contemporary Ophthalmology 12th Annual Scientific Assembly and the First International Glaucoma Congress will be held Jan. 30-Feb. 5, 1977, at the Diplomat Hotel in Hollywood, FL.

This continuing medical education activity meets the criteria for 42 hours of credit in Category 1 for the Physician's Recognition Award of the AMA and for the Certificate of Advanced Studies in Ophthalmology of the ASCO.

For information write: Dr. John Bellows, 30 N. Michigan Ave., Chicago, IL 60602.

There Is Risk in "Going Bare"

The physician who "goes bare"—practicing without malpractice insurance—runs the risk of complete financial ruin, says a report in a recent issue of the Impact section of *American Medical News*.

A recent survey by Impact found that 35 per cent of physician respondents said they are thinking of dropping malpractice coverage, while 13 per cent say they are currently without any malpractice insurance.

"Going bare" is a good idea "only for the very few toughminded individuals who can live with the possibility of losing everything they've acquired in a lifetime of practice, plus a good chunk of their future earnings," W. Fred Mangan, head of a Michigan management consultant firm, told the newspaper.

If the doctor drops his malpractice insurance, the only way he can keep from losing his assets in a future malpractice action is not to have any assets to lose. He has to give them away, Mangan pointed out. And the give-away must be complete and irrevocable, with the doctor retaining no control over the assets.

Some physicians have considered putting all property in their wife's name, but, says Mangan, the chances of losing everything through divorce are much greater than any risk from malpractice. He points out that the American divorce rate is now 43 per cent of marriages.

If the doctor has no insurance and few assets to pay a malpractice judgment, the plaintiff's lawyer likely will obtain a court order attaching future earnings.

The doctor who "goes bare" may end up exactly that—bare, the consultant declared.

Consumers' Directory Misleads Public

The first Consumers' Directory of Physicians, published in 1974 in Prince Georges County, Maryland, by Ralph Nader's Health Research Group, violated state law forbidding physician advertising, the Maryland Commission on Medical Discipline ruled. The commission said the "interpretive" introduction to the directory contained "inaccurate and naive" statements that could be "misleading to the unwary consumer." Jerome J. Coller, M.D., chairman of the commission, said that without the introduction the directory would have been acceptable.

Any future directory in the state must avoid any suggestion of endorsement and contain only "objective verifiable and accurate information," the commission said. It also ruled that "a physician would have to inquire into the proposed format and commentary of a directory to insure that no system of rating of physicians would be attempted." No disciplinary action will be taken against the 115 physicians who provided information for the directory, the commission said.

Compliments of

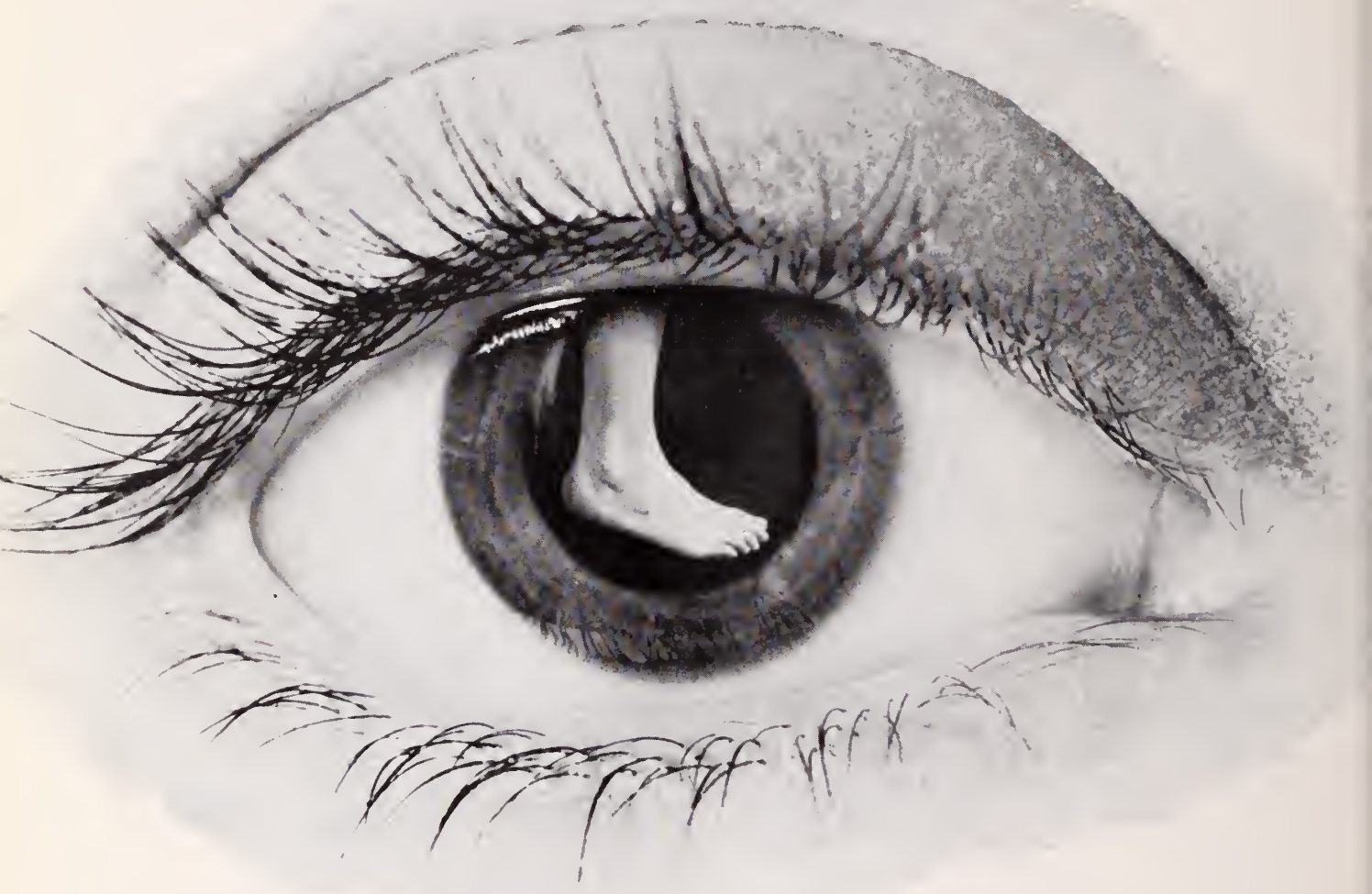
The Sheraton-Biloxi Motor Inn

3634 W. Beach—U.S. Hwy. 90

Biloxi, Mississippi 39531

601-388-4141

consider the effect on coexisting glaucoma when you prescribe a vasodilator*



a vasodilator that has not been reported to raise intraocular pressure

VASODILAN®
(ISOXSUPRINE HCl)

TABLETS, 20 mg.

the compatible vasodilator

Mead Johnson LABORATORIES

© 1980 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL-54118

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

NEWSLETTER

December 1976

Dear Doctor:

Figures from a survey conducted by the American Medical Association were released on October 18 and revealed that patients paid approximately $1.24 for medical liability insurance per visit to a physician in 1975. This amount represents the increased price of that insurance as passed on to the patient by the medical-care professional. The AMA said that the figure is a quadrupling of such costs since 1973.

> IMPORTANT NOTICE: Information about the Mississippi Medical Fraternal and Educational Society has been mailed to all Mississippi State Medical Association members. The society's Board of Directors urges all MSMA members to respond to the mailing as soon as possible.

"What the AMA Dues Dollar Does," report highlighting 1976 programs, will be included as a 16-page insert in the Dec. 13 American Medical News. Report presents breakdown of 1976 budget into 6 major activity areas: disseminating scientific information, representing the profession, serving the public, assisting physician and practice, upgrading care educationally and strengthening organized medicine.

Calif. Governor Brown has signed nation's first "right-to-die" law. Starting Jan. 1, physicians can disconnect life-support equipment from a dying patient who has authorized such discontinuance in advance, and cannot be sued. "Will" must be renewed every 5 years to remain valid. It can be acted on only after two MDs certify a patient is hopelessly ill, with death imminent.

Oregon Medical Association House of Delegates voted overwhelmingly to prohibit smoking at all meetings and convocations of the OMA, including regular committee meetings. Gerhard Tank, reference committee chairman, said, "It is most appropriate that this medical and scientific organization should act in accordance with its previous stands opposing pollution in all its forms."

The blue "Star of Life" has been adopted as the official medical emergency symbol to be used on ambulances purchased with federal funds. The symbol, a serpent and staff superimposed on three blue bands formed into a six-pointed star, identifies emergency vehicles purchased under the U.S. Department of Transportation Emergency Medical Service Program.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

helping you change things for the better

Canton Exchange Bank

A FULL SERVICE BANK

"Your Account Handled in Strict Confidence"

Each depositor insured to $40,000

Branch Offices
Canton East Branch
Bank Of Madison
Bank Of Ridgeland

FDIC

"Our 96th Year Of Continuous Service"

Federal Deposit Insurance Corporation

it's the real thing

Enjoy Coca-Cola Trade-mark ®

70-37

Mississippi Council of Coca-Cola Bottlers

Health Care Costs Increase

Total spending on health care in this country is estimated to jump from the current $140 billion to $223.5 billion in five years, according to an actuarial study prepared for HEW.

The study, which figures to be often-cited during next year's Congressional consideration of National Health Insurance (NHI) proposals, also predicts that any NHI plans will add at least $10 billion to the overall expenditures on health. The increased spending would come from "encouraging more use of health services covered by the plan, adding administrative expenses for the extra insurance and paying for bad debts in charity services," among other factors, the report said.

The spending impact of six major NHI plans was compared—those of the AMA, the American Hospital Association (AHA), the Health Insurance Association of America (HIAA), the Labor-Kennedy forces, Sens. Russell Long (D-LA) and Abraham Ribicoff (D-CT), and the Nixon Administration (CHIP).

The Long-Ribicoff measure focusing on catastrophic expenses would add the least to overall health spending by fiscal 1980 if put into effect next year—$9.8 billion.

Next on the list was the plan by the health insurance companies—$11 billion, followed by CHIP, $11.3 billion; the AMA plan, $20.3 billion; the Labor-Kennedy Program, $24.8 billion; and the ANA plan, $25.1 billion.

The study said Long-Ribicoff, CHIP, and the HIAA plans "tend to use a variety of cost-sharing mechanisms, limit preventive services to children, and concentrate most of their additional spending on the poor, while the AMA, AHA, and Health Security (Kennedy-Labor) proposals tend to have little or no cost-sharing, provide preventive services to everyone, and increase insurance coverage broadly for the general population."

"The greatest threat to our country is when people cease to care; The greatest threat to our profession is when its members cease to care."—Anon.

The ALLBEE® with C Scrapbook of Vitamin Facts & Fallacies



A study conducted among elderly patients in England showed that 41% were deficient in ascorbic acid on admission to the hospital. Even among those living at home and well, or not sufficiently ill for admission, 27% were deficient in ascorbic acid.

Griffiths, L.L., Brocklehurst, J.C., MacLean, R. et al. *Diet in Old Age*, Brit. Med J., 1 739, 1966.



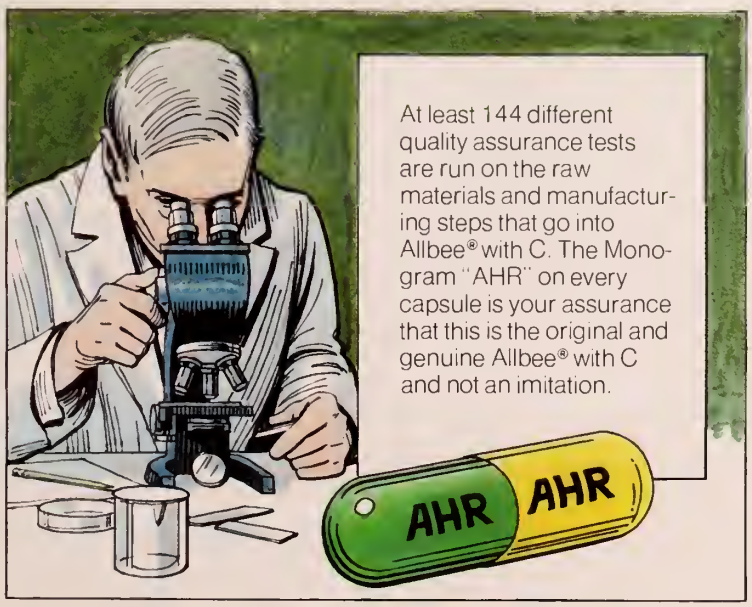
The loss of riboflavin in milk in a glass container exposed to sunlight for two hours may be as high as 95%.



Quick freezing of vegetables is accompanied by very little ascorbic acid loss. But blanching, washing, and prolonged standing at room temperatures results in considerable reduction in Vitamin C content.

In World War I a unit of 100 beds per division in the Russian army was set aside for scurvy patients. Yet, only 20 cases of scurvy were reported among all American troops in 1917-18.



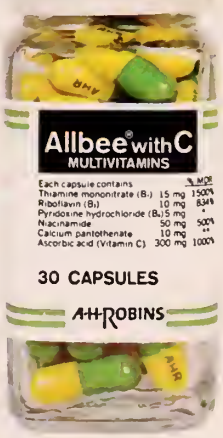


At least 144 different quality assurance tests are run on the raw materials and manufacturing steps that go into Allbee® with C. The Monogram "AHR" on every capsule is your assurance that this is the original and genuine Allbee® with C and not an imitation.

Available on your prescription or recommendation

ALLBEE® with C

High Potency B-Complex and Vitamin C Formula



A.H. Robins Company, Richmond, Va. 23220 A·H·ROBINS



Spasm reactor?

Donnatal®!

	each tablet, capsule or 5 ml tsp of elixir (23% alcohol)	each Donnatal No. 2 Tablet
Phenobarbital (warning: may be habit forming)	(¼ gr) 16.2 mg	(½ gr) 32.4 mg
Hyoscyamine sulfate	0.1037 mg	0.1037 mg
Atropine sulfate	0.0194 mg	0.0194 mg
Hyoscine hydrobromide	0.0065 mg	0.0065 mg

Indications: Based on a review of this drug by the NAS/NRC and/or other information, FDA has classified the following indications as possibly effective: adjunctive therapy in the treatment of peptic ulcer; the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

Brief summary. Contraindicated in patients with glaucoma, renal or hepatic disease, obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy) or a hypersensitivity to any of the ingredients. Blurred vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur at higher dosage levels, rarely at the usual dosage.

A·H·ROBINS A. H. Robins Company Richmond, Virginia 23220

State Health Planning Agencies Located

A recent report from the Bureau of Health Planning and Resources Development indicates that Mississippi is among a minority of states having their State Health Planning and Development Agencies under Public Law 93-641 located in the governor's office.

Some 48 state agencies have now been named and of that total only six are in the governor's office. Twenty-two of the agencies named are in state health departments and the remaining 13 are in state departments of human resources.

Governor Cliff Finch by Executive Order designated his own office as the State Planning and Development Agency under Public Law 93-641 earlier this year.

Medical Center Works on Minority Enrollment

The University of Mississippi Medical Center has begun a cooperative program with five predominately black colleges to help increase the number of minority physicians and dentists in the state.

Three state universities, Alcorn, Jackson State, and Mississippi Valley State, and two private colleges, Rust and Tougaloo, are joining with the Medical Center in the program designed to make the minority applicant pool of pre-medical and pre-dental students larger and more competitive.

A three-year grant from the Robert Wood Johnson Foundation to the Medical Center funds the consortium program.

Anticipated total support is $433,705, with $109,818 awarded for the first year, according to UMC Vice Chancellor Dr. Norman C. Nelson.

The two-phase program will encourage individual academic achievement and help each cooperating institution strengthen undergraduate education for pre-medical and pre-dental students. Participants will take additional assignments to complement required courses during the regular academic year and meet quarterly at the Medical Center for special seminars. Eight-week summer sessions will reinforce previous study.

Twenty-five freshmen, five from each undergraduate school, will be selected at the end of their first semester in college to participate in the pilot program, with additional groups of 25 to be enrolled in succeeding grant support years.

Contemporary Medicine and Surgery Society Meets

The 1977/Twelfth Annual Scientific Assembly of the American Society of Contemporary Medicine and Surgery will be held Jan. 30-Feb. 5 at the Diplomat Hotel in Hollywood, FL.

The program includes seminars and tutorials on cardiovascular disease, hypertension, cancer, infectious disease, cryosurgery, nutrition/alimentation, special medicine and surgery, genitourinary disease, and pulmonary disease.

The permanent faculty of 100 leaders of American medicine is headed by the ASCMS president, Dr. Michael DeBakey.

This continuing medical education activity meets the criteria for 40 hours of credit in Category 1 for the Physician's Recognition Award of the AMA and for the Certificate of Advanced Medical Studies of the ASCMS. For information, write: Dr. John Bellows, 30 N. Michigan Ave., Chicago, IL 60602.

FAMILY PHYSICIANS

OAKDALE, LOUISIANA needs three Family Physicians immediately. Oakdale, population 7,500, business trade 25,000, is located in Central Louisiana near Alexandria. It is a thriving community with a diversified economic base. A new, modern equipped, 61-bed, JCAH accredited hospital completed in 1973.

FINANCIAL ASSISTANCE AND OFFICE SPACE AVAILABLE

For detailed information call collect or send Curriculum Vita, Administrator, Oakdale General Hospital, 130 North Hospital Drive, Oakdale, Louisiana 71463 (318) 335-3700.

HUMANA, INC.
THE HOSPITAL COMPANY
P.O. BOX 1438
LOUISVILLE, KY 40201

Riverside.

Mississippi's Unique Psychiatric Hospital.

Riverside Hospital is unique in Mississippi.

As a privately owned 56-bed short term care facility for treating patients with psychiatric illness or emotional problems, it is the only hospital of its kind in the state.

Architecturally designed to create an attractive open environment, Riverside's "non-institutional" atmosphere helps prepare the patient for specific therapy, healthy entertainment and physical recreation.

The clinical program incorporates a wide range of modern psychiatric ideas. Emphasis is placed on interpersonal relationships, small group functions, and professional individualized care.

The Medical Staff includes a large number of physicians in private practice in the Jackson area. All are qualified and limit their practice to psychiatry.

Riverside is licensed by the Mississippi Commission on Hospital Care, and fully accredited by the Joint Commission on Accreditation of Hospitals.

For additional information contact: John R. Reedy, Executive Director.



Riverside Hospital

P.O. Box 4297, Jackson, MS 39216
Telephone: (601) 939-9030

DATELINE

Foreign Health Care Systems Are Studied

Chicago, IL - Detailed studies of the French and British health care systems are presented in two new books published by AMA. They offer in-depth studies of the health care systems of both nations, how those systems operate and what they mean to users and to people who work within them. Studies conducted by Economic Models, Ltd., conclude that each system has problems, but that for the most part the people in each country support them. For copies, write Order Dept., AMA.

Patient Booklets Help Prevent Malpractice

Pacific Palisades, CA - New Patient Information Booklets, averaging 32 pages, with large, clear typeface and simple illustrations, are now available from Pinecliff Publishing Company. Booklets carry a wealth of information for concerned patients on such subjects as cataracts, gall bladder disease, lump in the breast, prostate trouble and back trouble. Booklets help prevent malpractice suits based on uninformed-patient claims or lack-of-consent.

Marijuana Is Tested to Treat Glaucoma

Washington, DC - Howard University ophthalmologist Dr. John Merritt has begun testing marijuana as an eye drop to treat glaucoma. He will put synthetic marijuana liquid in rabbits' eyes and distribute marijuana cigarettes or capsules to human glaucoma patients to determine if the weed can help control effects of the disease. FDA approved trials, which will use marijuana provided by National Institute on Drug Abuse. If animal tests are successful, eye drops will be tried on humans.

Preschoolers Need Regular Exercise

Evanston, IL - Encouraging preschool children to exercise and develop physical capabilities could help develop habits that can prevent disease in adulthood, an American Academy of Pediatrics committee said in the July issue of Pediatrics. Committee said normal play activities of children can form the basis for a lifelong habit of exercise which will help prevent obesity and lower the incidence of coronary heart disease and atherosclerosis and increase cardiopulmonary efficiency.

AMA Testifies on Medicare Fees

Washington, DC - The solution to physician reimbursement problems under Medicare "will occur only when Congress is willing to adopt a policy of reimbursing for services rendered at a level more nearly reflective of usual and customary charges," AMA board chairman R. T. Holden told House Ways and Means Subcommittee on Health. Physician charges are based on data that is up to two years old, meaning physicians absorb today's increased costs while being reimbursed on basis of yesterday's fees.

SBH Makes Flu Report

The Mississippi State Board of Health reports that through Nov. 13, 1976, 20 per cent of the eligible 18 year and over population in Mississippi had received the Swine Flu vaccination. Nationwide through Nov. 13, 1976, 14 per cent of the eligible 18 year and over population had been vaccinated.

During the 1976-77 flu season the Board of Health will conduct an influenza surveillance program in the state consisting of voluntary reporting from health personnel and schools, a weekly telephone survey of physicians' offices, laboratory testing, review of absenteeism reports from selected schools and industries, reports on school closings, and review of emergency and outpatient visits for upper respiratory infections at the UMC.

Nurses Want Better Schools

The Mississippi Nurses Association has called on the Board of Trustees of Institutions of Higher Learning to establish minimum admission standards and upgrade instruction at the state's 21 nursing schools. The request follows closely a report from the Mississippi Board of Nursing showing that 28 of every 100 Mississippi nursing school graduates fail the licensing exam on their first try, one of the highest failure rates in the country.

Most of the state's 21 nursing programs are located in junior colleges where according to the MNA very few of the instructors have attained their Masters in nursing. Further, although all the nursing schools give the American College Test (ACT) to entering students, there is no standard score required for admission. One program uses an ACT score of 12 for admission whereas the national average score is 18. The same school had 20 of 24 graduates failing the licensing exam this year.

Mother and Child Cards Benefit Newborn Center

Christmas and all-occasion note cards now on sale through the University of Mississippi Medical Center will benefit the UMC Advancement of the Newborn Fund.

The cards bear an embossed impression of Jackson sculptor Lewis West's work "Mother and Child," judged "best in show" and winner of the adult purchase award in the UMC Newborn Center-March of Dimes sponsored art contest this summer.

The newborn fund is a special resource which helps meet extraordinary needs of the Newborn Center, not covered by usual budgeted funds.

The cards, printed in wedgewood blue ink on heavyweight white cover stock, come with a traditional holiday greeting for seasonal mailings or plain for use as note cards year-round.

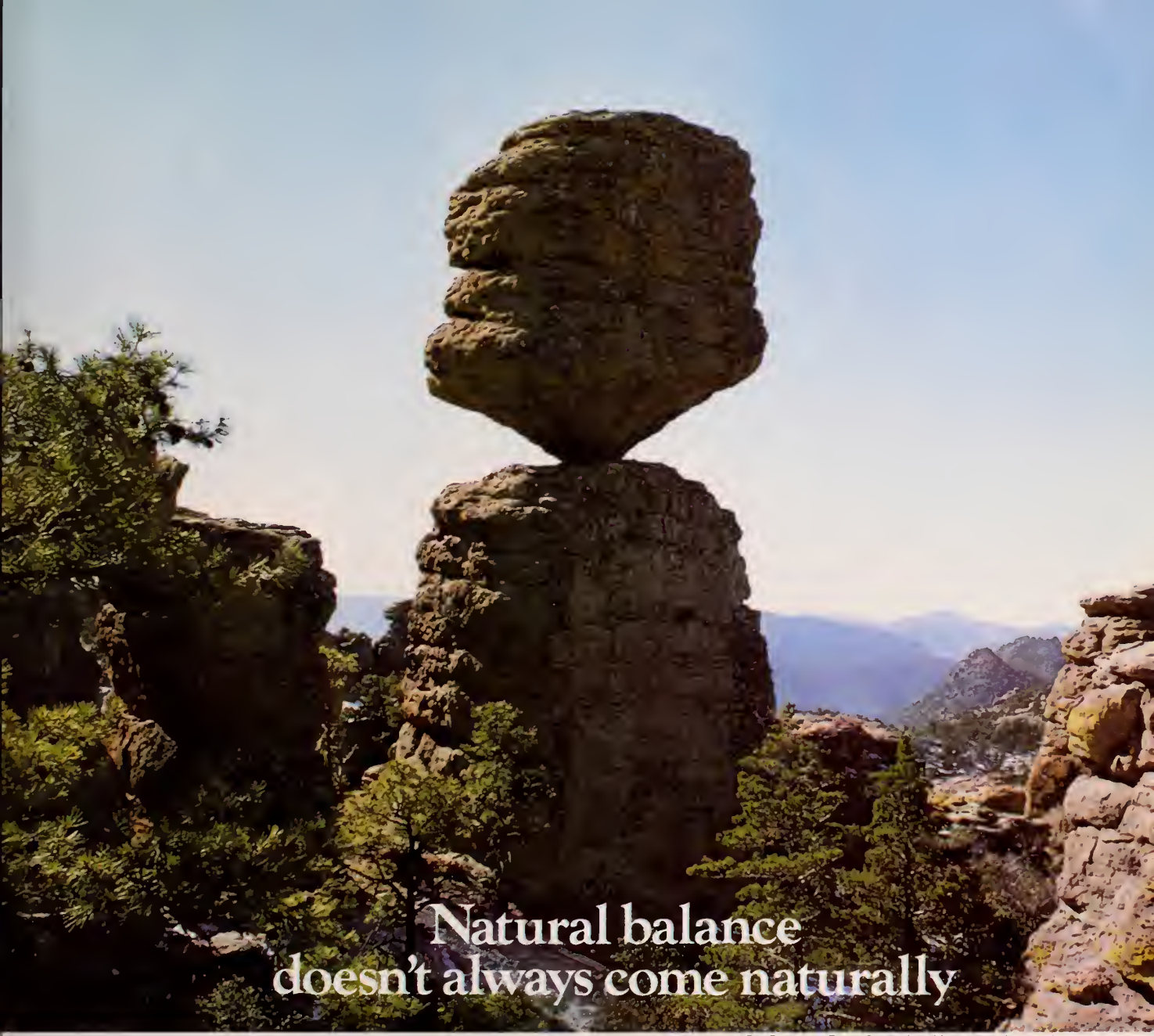
Both Christmas and note cards have a brief narrative describing the limestone sculpture and the artist's interpretation of his work.

The cards are $.35 each, $3.00 for packets of 10, or $6.00 for packets of 20 with matching envelopes. Mail orders should be addressed to Special Services, University Medical Center, 2500 North State Street, Jackson 39216.

Checks should be made payable to the UMC Newborn Fund and include $.50 for postage and handling.



An embossed impression of Lewis West's limestone sculpture "Mother and Child" is art for Christmas and all-occasion note cards currently on sale for benefit of the University Medical Center Newborn Fund.



Big Balanced Rock, Chiricahua Mountains, Arizona (approx 1,000 to

■ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

■ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*

■ **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pre nancy or to women who may become pregnant is contraindicated in view of th teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestatio has produced cleft palate in the offspring. Limited studies using doses of over 100 mg kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palat Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hype sensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patien should be warned of this possibility and cautioned against driving a car or operatin dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in childre have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

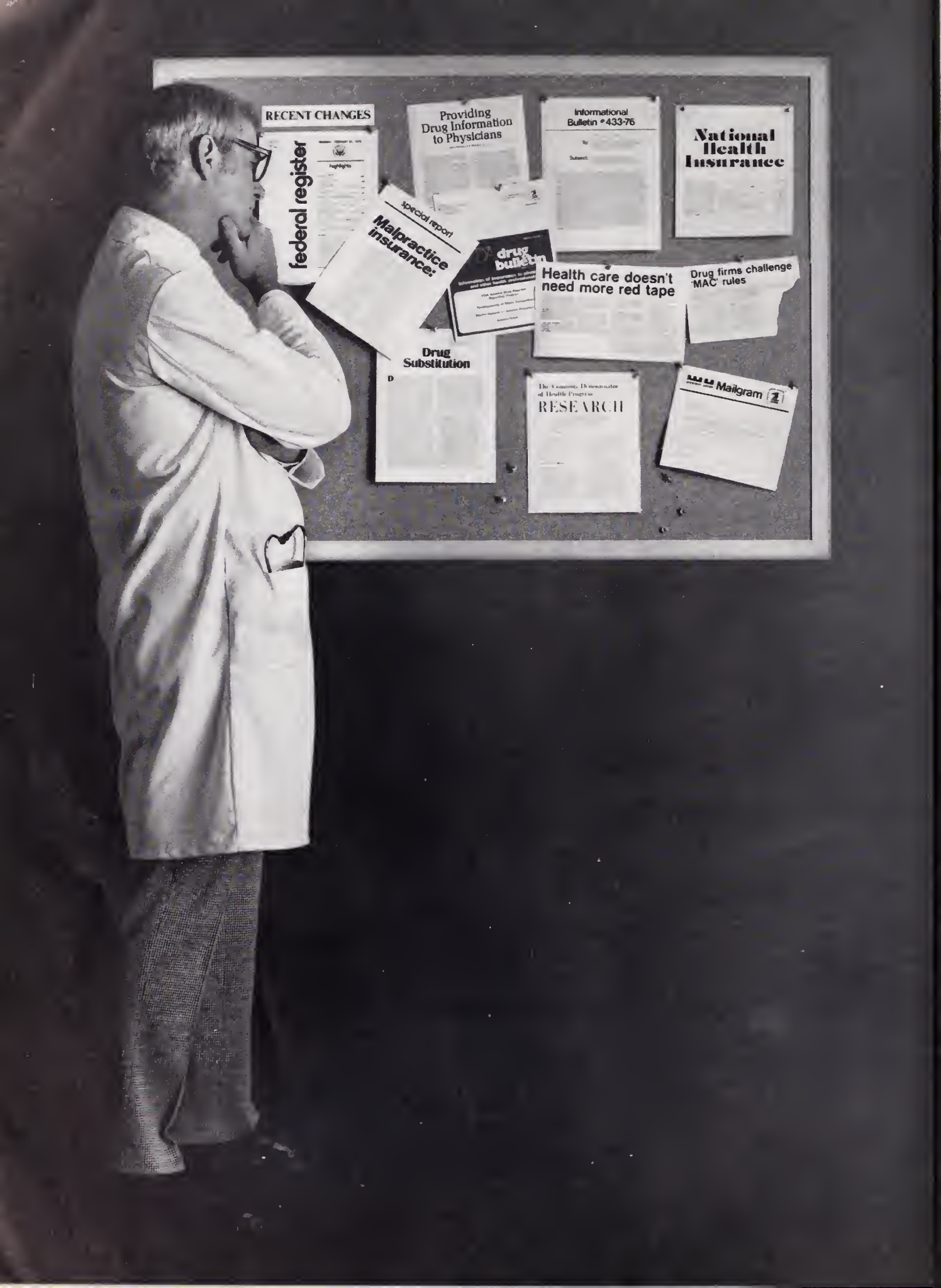
ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurr vision have been reported.

More detailed professional information available on request.

ROERIG Pfize
A division of Pfizer Pharmaceutica
New York, New York 10017

Antivert®/25

(meclizine HCl) 25 mg. Tablets
for vertigo*


RECENT CHANGES
federal register
Providing Drug Information to Physicians
Informational Bulletin #433-76
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Applications are now being accepted for scientific exhibit space for the MSMA 109th Annual Meeting to be held May 2-5, 1977, in Biloxi.

For information, write to:

Note: Space is limited so get your application in early.

Chairman, Scientific Exhibits
MSMA
P.O. Box 5229
Jackson, MS 39216

Hill Crest
HOSPITAL
Hill Crest Foundation, Inc.

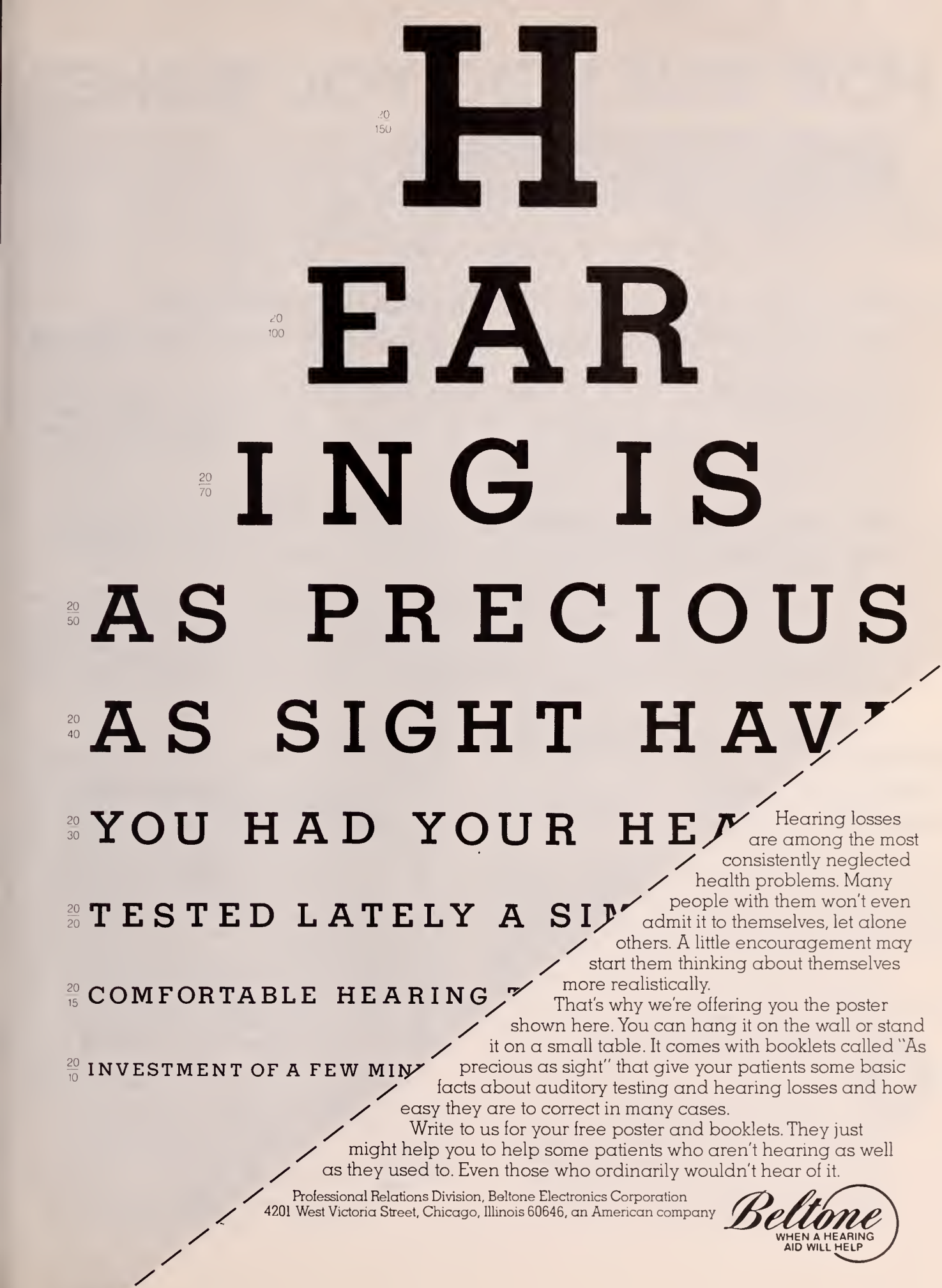
A non-governmental psychiatric hospital. Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved.
Phone: 205-836-7201



A short-term, intensive treatment center for psychiatric disorders, alcoholism, and drug abuse.

Member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Birmingham Regional Hospital Council.

6869 Fifth Avenue South
Birmingham, Alabama 35212



Hearing losses are among the most consistently neglected health problems. Many people with them won't even admit it to themselves, let alone others. A little encouragement may start them thinking about themselves more realistically.

That's why we're offering you the poster shown here. You can hang it on the wall or stand it on a small table. It comes with booklets called "As precious as sight" that give your patients some basic facts about auditory testing and hearing losses and how easy they are to correct in many cases.

Write to us for your free poster and booklets. They just might help you to help some patients who aren't hearing as well as they used to. Even those who ordinarily wouldn't hear of it.

Professional Relations Division, Beltone Electronics Corporation
4201 West Victoria Street, Chicago, Illinois 60646, an American company

Beltone
WHEN A HEARING AID WILL HELP

HOW MUCH DO YOU MAKE?

That's how much you could lose . . . and more . . . if an accident or illness totally disabled you and you were unable to continue your practice. Not only would you lose your personal income, but the cost of maintaining your office would also continue. YOU COULD LOSE TWICE AS MUCH as another person might because you have two sets of expenses. To help you fight this possibility, the Mississippi State Medical Association makes available to members two excellent programs that help cover both ends of your expense picture: the INCOME PROTECTION PROGRAM for personal expenses, and the tax-deductible PROFESSIONAL OVERHEAD EXPENSE PROTECTION PROGRAM for your business expenses.

■ TO HELP PAY YOUR PERSONAL EXPENSES, THERE'S MSMA'S INCOME PROTECTION PROGRAM

When you're not practicing, your income stops. Just paying your everyday expenses could run into a great deal of money, draining your savings, especially if your income were cut off indefinitely. The MSMA INCOME PROTECTION PROGRAM can pay as much as $2,000 a month income replacement benefits payable for up to LIFETIME for accident-caused disabilities, TO AGE 65 for disabilities resulting from illness. And, you choose when you want the benefits to begin — either the 31st or the 91st day of disability — to give you the coverage that best fits your own individual needs.

■ TO HELP PAY BUSINESS COSTS, PROFESSIONAL OVERHEAD EXPENSE PROTECTION'S FOR YOU

Whether you're there or not, it costs the same amount of money each month to keep your office open. But, with no money coming in, it could really put you in a serious financial position. You need the businessman's insurance with your practice in mind — the MSMA PROFESSIONAL OVERHEAD EXPENSE PROTECTION PROGRAM. It works for you when you can't. It'll pay 100% of your covered fixed overhead costs — even up to $3,500 a month, the maximum amount available. And, the benefits are available for as long as 18 months. Premiums may be deducted as a direct business expense, too.

WANT TO KNOW MORE? WRITE TODAY!

Protect yourself and your family. Protect your investment in your business. Find out more about these exceptional MSMA Programs. Write to THOMAS YATES & CO., P. O. Box 1054, Bankers Trust Plaza Building, Jackson, Mississippi 39205 for brochures describing the benefits, features, limitations, exclusions and premiums of each Plan.

These Plans Are Offered By

THOMAS YATES & CO.
P.O. Box 1054
Bankers Trust Plaza Building
Jackson, Mississippi 39205

THOMAS YATES & CO. has been awarded the seal of the American Institute of Professional Association Group Insurance Administrators — "In recognition of professional excellence in serving clients with an integrity worthy of the highest trust." Membership in the Institute is by invitation only.

THESE PLANS ARE MSMA SPONSORED

The INCOME PROTECTION PROGRAM and the PROFESSIONAL OVERHEAD EXPENSE PROTECTION PROGRAM are officially sponsored and endorsed by the Mississippi State Medical Association exclusively for its members.

Also sponsored by the MSMA are the HOSPITAL MONEY PLAN, MAJOR MEDICAL PLAN, EXCESS MAJOR MEDICAL PLAN, and TERM LIFE INSURANCE. Brochures for these programs are also available.

Underwritten By

CONTINENTAL CASUALTY Co.
Association Group Division
CNA Plaza • Chicago, Illinois 60685

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
December 1976, Vol. XVII, No. 12

ORIGINAL PAPERS

The Recognition and Management of Blastomycosis

GEORGE E. McGEE,* HAMP D. WILLIAMS,* and
GUY D. CAMPBELL, M.D.
Jackson, Mississippi

North American blastomycosis is a systemic mycotic disease with a high incidence in Mississippi. The disease originates primarily as a pulmonary infection with the possibility of hematogenous spread to multiple organ systems. The authors discuss definitive diagnosis, drugs used in treatment and prognosis.

INTRODUCTION. North American blastomycosis is a chronic granulomatous disease caused by the thermally dimorphous fungus *Blastomyces dermatitidis.* Primarily a pulmonary infection, this systemic mycotic disease is capable of disseminating to numerous other organs notably the skin, bone, and genitourinary tract. The disease is generally confined to limited geographical regions and Mississippi seems to be located in the heart of the major endemic area. Because of the high prevalence of this fungal disease in Mississippi, physicians should be aware of its multiple manifestations and consider it in the differential diagnosis of many disease states.

History. B. dermatitidis was first isolated and described by Gilchrist in 1894, establishing the organism as the cause of what became known as "Gilchrist's disease." Much of the early investigation originated in the Chicago area, with the result that the disease also became known as "Chicago disease." As cases of blastomycosis began to be reported, it became apparent that the disease was not limited to the Chicago area, but was much more widespread than originally thought.

Epidemiology. The epidemiology of blastomycosis is probably the least understood of the major systemic fungal infections. It is generally believed that blastomycosis is acquired as a primary pulmonary infection. With rare exception, cutaneous lesions and extra-pulmonary organ involvement are the result of hematogenous dissemination of the organism from the lung.

Most mycologists believe that man is infected with the organism from a soil reservoir; however, attempts to culture the organism from the soil have been inconsistent.

B. dermatitidis infection is also widespread among dogs and occasionally occurs in horses, cats, and other animals. Studies indicate that the geographic distribution of canine blastomycosis appears to parallel that of human blastomycosis.[1] It is not generally believed that animal-to-man transmission occurs; however, recently one such transmission has been reported as a primary infection from a dog bite.[2]

Most cases of human blastomycosis have occurred in men.[1] In a retrospective study of 198 cases of blastomycosis, Busey noted that 50 per cent of cases were in the 30 to 49 year age group.[3] Blastomycosis can occur in children with the same clinical manifestation as that found in adults.[4] Patients representing almost all occupations have been infected with *B. dermatitidis,* but studies suggest an increased incidence of the disease in people with occupations closely related to the soil.[3]

Although the disease has occasionally been reported from all regions of this continent, most cases have been in the Mississippi-Ohio River Valley and the central Atlantic states. Many of those cases oc-

From the Medical Service, Veterans Administration Hospital and Department of Medicine, University of Mississippi School of Medicine, Jackson, MS.
* Supported by summer fellowships provided by Mississippi Lung Association.

curring elsewhere were found in patients who had migrated earlier from the endemic area. In a survey of reported cases from 1885 to 1968, Mississippi was found to have the greatest number of cases per 100,000 population.[1] In a study of the veteran population, Mississippi also had the highest incidence of blastomycosis per 100,000 veteran population.[3] When the places of residence of blastomycosis patients within the state of Mississippi were analyzed, no specific areas of endemicity could be recognized.[5]

Manifestations. Blastomycosis originates as a primary pulmonary infection. Inhalation of the spores introduces the primary infection into the lung, often with subsequent hematogenous spread to other sites including skin, bone, urinary tract, and rarely, such sites as liver, spleen, larynx, heart, endocrine glands, gastrointestinal tract, and the central nervous system. Therefore, the presenting symptoms of blastomycosis can be extremely varied depending on the systems involved.

Pulmonary blastomycosis may mimic many diseases in its presentation including carcinoma, tuberculosis, and other pneumonic processes. Presenting symptoms are varied and may include cough, hemoptysis, dyspnea, generalized chest pain, weight loss, chills, fever, and various other nonspecific complaints.



Figure 1. Blastomycosis presenting as a left hilar mass suggesting bronchogenic carcinoma.

The roentgenographic picture is extremely varied and there is no predilection for involvement of any certain lung area. The roentgenogram may be suggestive of carcinoma, especially when presenting as a hilar mass (see Figure 1). When the lung apices are involved, a presumptive diagnosis of tuberculosis is often erroneously made. Cavitary lesions are frequent in blastomycosis and may mimic tuberculosis or lung abscess. Other roentgenographic findings include infiltrative, nodular and miliary processes, hilar and/or mediastinal lymphadenopathy and pleural effusion.[3]

With rare exception, cutaneous blastomycosis results from hematogenous spread from a primary pulmonary infection. The typical secondary skin lesion is a raised, scaly lesion with irregular borders sharply demarcated from the adjacent normal skin. The lesions have a tendency to heal centrally, with micro-abscesses frequently found in the periphery. The lesions are often mistaken for epithelioma, squamous cell carcinoma, and various other skin diseases. Regional lymphadenopathy is not a characteristic of the secondary skin lesion.[6]

Several cases of primary cutaneous blastomycosis have been reported, usually occurring after accidental self-inoculation by laboratory personnel.[6] These rare lesions have less sharply demarcated borders and tend to ulcerate. Regional lymphangitis and lymphadenopathy are characteristic of the primary cutaneous lesion.

Bone lesions are fairly common in blastomycosis and may involve long, short, sesamoid, and flat bones. The lesions may present as focal or diffuse osteomyelitis. Fistulae may develop as a result of soft tissue invasion from the bone lesion.[7]

Genitourinary involvement has been shown in various studies to be present in from 16 to 45 per cent of cases of blastomycosis and occurs more commonly in men. In 50 per cent of these patients, urogenital infection was limited to the prostate gland.[8]

The diagnosis of blastomycosis depends on the demonstration of the causative organism. This may be accomplished by smear and culture of various appropriate clinical specimens, including sputum, gastric washings, urine, spinal fluid, bone marrow, abscess material, or prostatic secretions. Histologic sections of biopsy material stained with silver methenamine showing characteristic micro-abscesses, giant cells, and epithelial hyperplasia, along with the yeast-like organism, are also sufficient for a positive diagnosis.

Direct microscopic examination of a clinical specimen is simple, rapid, and may be adequate for a clinical diagnosis if examined by properly trained

personnel. Specimens should be placed on a clean slide, and mixed with a drop of 10 per cent potassium hydroxide to remove cellular debris. Microscopic demonstration of typical *B. dermatitidis* reveals spherical, refractile cells, 8 to 15 μ in diameter, with a single bud attached to the parent cell by a wide pore (see Figure 2).

Culture of the organism on the Sabhi media (with and without blood) allows laboratory personnel to definitely identify *B. dermatitidis*. Cultures incubated at 37°C. show characteristic wrinkled colonies with budding yeast cells. Cultures at room temperature show the white, cottony mycelial-phase growth.

Skin tests, complement fixation studies, and agar gel precipitin testing have been used in the diagnosis of North American blastomycosis; however, their usefulness has not matched that found in the diagnosis of such fungal diseases as coccidioidomycosis and histoplasmosis. In a Veterans Administration study of 198 cases of unequivocally proven blastomycosis, 59 per cent had negative reactions to the blastomycin skin test.[3] In addition to the lack of sensitivity, the blastomycin skin test suffers from undesirable cross-reactions with antigens from other fungal diseases which must be included in the differential diagnosis. The skin test antigen is currently not commercially available. Complement fixation studies on the same group of veterans were reported as positive in only 48 per cent.[3] Agar gel precipitin tests are considered to be more sensitive than complement fixation tests; however, they also lack specificity from other fungal diseases and are available only from limited sources.[9]

Treatment. There are currently two drugs used in the treatment of blastomycosis, 2-hydroxystilbamidine and amphotericin B. Both drugs are administered intravenously, are light-sensitive, and have potentially serious side effects.

2-hydroxystilbamidine, in use since 1953, is an aromatic diamidine that has been found to be highly effective in treating cutaneous and limited non-cavitary pulmonary blastomycosis.[10] The drug is administered daily in dosages of 225 mg. in 200 ml. of five per cent dextrose in water over a period of 30 to 60 minutes. The solution should be mixed just before administration to prevent immediate side effects such as nausea and vomiting. Therapy is continued until a minimum of 8 to 12 gm. has been administered. Toxic side effects of 2-hydroxystilbamidine are related primarily to the liver, especially evidenced by increasing SGOT levels.

Amphotericin B, a polyene antibiotic, has been shown to be highly effective in treating all clinical types of blastomycosis and has a smaller relapse rate than that of 2-hydroxystilbamidine.[10] Amphotericin B, however, has a higher incidence of toxic side effects, including anemia, nausea, hypokalemia, chills, fever, and nephrotoxicity. For intravenous



Figure 2. KOH preparation of sputum demonstrating a round thick walled blastomycete with the classical wide opening between the parent cell and the bud.

administration, amphotericin B is dissolved in 5 per cent dextrose in water. It should be administered over a period of 30 minutes to one hour in order to minimize immediate side effects and is generally given three times per week; a Monday-Wednesday-Friday schedule is usually convenient. In cases of severe disease, it may be necessary to administer amphotericin B daily until the patient is stable. Initial dosages of amphotericin B should be small, about 5 mg. in 100 ml. of 5 per cent dextrose in water, and increased from dose to dose by increments of 5 or 10 mg. of amphotericin B and 50 or 100 ml. of 5 per cent dextrose in water, respectively. The maximum daily dose of amphotericin B should not exceed 50 mg. Therapy should be continued until a minimum of 2000 mg. has been administered. Side effects such as chills, fever, nausea, and vomiting may be minimized by premedicating the patient with 50 mg. of diphenhydramine and 10 grains of aspirin 30 minutes before the infusion. Twenty-five mg. of heparin added to each infusion appears to decrease the incidence of phlebitis which frequently occurs in the vein where amphotericin B is introduced. Hydrocortisone has been added to infusions of amphotericin B to reduce the side effects, but the benefits are not clearly demonstrated. When marked rises in BUN (over 50 mg. per cent) or other signs of severe renal toxicity develop, it is necessary to reduce the dosage and then gradually increase to the desired daily dose. After the patient is stabilized at a maximum desired dosage, he may receive his treatment on an outpatient basis and can then return to most of his normal activities. It is important that

patients receiving amphotericin B be closely followed for evaluation of renal function, especially with BUN, creatinine clearance, hemoglobin, and electrolytes throughout therapy.

It is to be noted that the effective minimum dosages of neither amphotericin B nor 2-hydroxystilbamidine, has been determined. Ultimate determination will depend on further clinical trials.

Clinical Course and Prognosis. The primary pulmonary infection may range from a small single infiltrate to multiple infiltrates of various sizes. Although the lung lesions are classically chronic in their course, more acute and rapidly spreading areas of involvement are not uncommon. Pneumonic consolidations involving large portions of the lungs may occur. Widespread fine or coarse nodular lesions are thought to result from a massive pulmonary inoculation.

Dissemination of the disease from the lungs to other parts of the body may occur at any time. In some instances dissemination develops early and is present from the time the pulmonary lesion is recognized, yet in other cases it may not occur until after months or years of pulmonary existence. It is not uncommon to find dissemination with little or no evidence of pulmonary involvement. In such situations it is believed that the primary lung lesion cleared spontaneously but not before systemic dissemination had developed.

Blastomycosis has a serious prognosis when untreated. Prior to the introduction of effective chemotherapy, the mortality rate was reported as ranging up to 90 per cent in recognized cases, but less than 15 per cent mortality can be expected with proper chemotherapy.[3] Cases with more widespread dissemination generally account for the treatment failures.

There are instances where the diagnosis of blastomycosis has been made following the total excision of a skin, lung, or other tissue lesion. There has been a temptation not to treat such patients; however, experience has taught that they should be treated.

It is now apparent that many factors affect the prognosis of patients with blastomycosis. The presence of concurrent disease, such as tuberculosis, worsens the prognosis. Extent of the disease also affects the prognosis, as evidenced by the fact that patients with disease limited to skin involvement have a much better prognosis than patients with more extensive disease. Caucasians appear to have a better prognosis than blacks, and men better than women. Age is also a factor as there is a higher mortality in older age groups. The type and amount of therapy received also affects prognosis as would be expected.

Recently it has been theorized that some acute blastomycosis cases are self-limited and require no therapy. Several cases believed to fall in this category are being closely followed without therapy to determine if recurrence or dissemination develops.[11] In view of the serious prognosis associated with dissemination, at the present time it appears wise to continue to treat all patients in whom the diagnosis is established.

SUMMARY

North American blastomycosis is a systemic mycotic disease which has a relatively high incidence rate in Mississippi. Blastomycosis originates primarily as a pulmonary infection with the possibility of hematogenous spread to multiple organ systems. Definitive diagnosis depends on demonstration of the causative organism by smear, culture, or tissue biopsy. Drugs used in the treatment of blastomycosis are 2-hydroxystilbamidine, which has fewer toxic effects but a larger relapse rate, and amphotericin B, which is a more effective but more toxic drug. Prognosis depends on many factors, but has improved markedly since the advent of effective drug therapy. ★★★

Dr. Campbell—1500 Woodrow Wilson (39216)

ACKNOWLEDGEMENT

The writers gratefully acknowledge the guidance and support of Dr. John F. Busey and the assistance of Mrs. Mildred McNease.

REFERENCES

1. Furcolow, M. L., Chick, E. W., Busey, J. F. and Menges, R. W.: Prevalence and Incidence Studies of Human and Canine Blastomycosis. I. Cases in the United States, 1885-1968. Amer. Rev. Resp. Dis. 102:60-67, 1970.
2. Jaspers, R. H.: Letter: Transmission of Bastomyces From Animals to Man. J. Am. Vet. Med. Assoc. 164:8, 1974.
3. Busey, J. F.: Blastomycosis: A Review of 198 Collected Cases in Veterans Administration Hospitals. Amer. Rev. Resp. Dis. 89:659-672, 1964.
4. Gill, J. A. and Gerald, B.: Blastomycosis in Childhood. Radiology 91:965-968, 1968.
5. Lockwood, W. R., Busey, J. F., Batson, B. E. and Allison, F., Jr.: Experiences in the Treatment of North American Blastomycosis With 2-hydroxystilbamidine. Ann. Intern. Med. 57:553-562, 1962.
6. Wilson, J. W., Cawley, E. P., Weidman, F. D. and Gilmer, W. S.: Primary Cutaneous North American Blastomycosis. A.M.A. Arch. Dermat. 71:39-45, 1955.
7. Gehweiler, J. A., Capp, M. P. and Chick, E. W.: Observations on the Roentgen Patterns in Blastomycosis of Bone. Amer. J. Roentgen. 108:497-510, 1970.
8. Malin, J. M., Anderson, E. E. and Weber, C. H.: North American Blastomycosis of the Urogenital Tract. J. Urol. 102:754-757, 1969.
9. Busey, J. F. and Hinton, P. F.: Precipitins in Blastomycosis. Am. Rev. Resp. Dis. 95:112-113, 1967.
10. Busey, J. F.: Blastomycosis. 3. A Comparative Study of 2-hydroxystilbamidine and Amphotericin B Therapy. Am. Rev. Resp. Dis. 105:812-818, 1972.
11. Sarosi, G. A., Hammerman, K. J., Tosh, F. E. and Kronenberg, R. S.: Clinical Features of Acute Pulmonary Blastomycosis. New Eng. J. Med. 290:540-543, 1974.

Complete Histological Examination of Excised Skin Cancers for Adequacy of Excision

JIM M. BROCK, M.D.
McComb, Mississippi

A method of complete histological examination of excised skin cancer for adequacy of excision is presented. Excised tissue is cut into 1½-2 cm. blocks. Horizontal frozen sections of the base and vertical frozen sections of the peripheral edge of each tissue block are done and then stained for 5 seconds with 0.5 per cent thionine in 20 per cent alcohol. This examination affords rapid complete histological examination and is designed to be done at the time of surgery.

FOLLOWING SURGICAL excision of skin cancer, immediate repair by direct closure, graft, or skin flap is most desirable. It is therefore imperative that histological examination of the excised tissue be done at the time of surgery to prevent burying tumor cells in the wound. This histological examination must be complete, that is, *ALL* of the base and *ALL* of the peripheral edges of the excised tissue must be examined.

The following frozen tissue techniques, derived from the histological method of Mohs chemosurgery[1] and Tromovitch's fresh tissue chemosurgery,[2] can be done at the time of surgery. This histological examination requires only 10 to 20 minutes, depending upon the size of the tissue excised. Afterwards, surgical repair can be performed.

Surgical requirements include:

1. The tumor plus a clinically adequate border and depth of normal tissue are surgically excised.
2. Skin should be incised at a 90 degree angle to the surface and the undersurface of the excised tissue should be level and parallel with the epidermis to facilitate cutting sections from this surface.
3. Place suture in superior edge of excised tissue for orientation.
4. Location of excised tissue on a map with proper orientation is essential. (Surgical Map)

Laboratory requirements are:

1. CO2 microtome or cryostat
2. 0.5 per cent thionine in 20 per cent alcohol

The frozen section procedure is as follows:

1. Cut tissue into equal sized blocks of 1½-2 cm. diameter (see Figure 1 and photograph No. 1). Identify blocks on surgical map.
2. To each block apply blue dye (Bonney's Bluing) to one cut edge and red dye (20 per cent merecurochome aqueous solution) to an adjacent cut edge (see Figure 2 and photograph No. 2).
3. Place block on microtome upside down (epidermis down and subcutaneous tissue up). Freeze tissue and cut a frozen section 6 microns thick. Transfer section to glass slide and blot firmly dry. Apply 0.5 per cent thionine in 20 per cent alcohol to slide for 5 seconds. Gently wash with tap water and blot dry. Apply a drop of glycerine (or permamount) and overlay with cover slip. This horizontal section of the base is marked 1A.
4. Return tissue to cutting block right side up (epidermis up) and cut a vertical ribbon of tissue from the peripheral edge (see Figure 3 and photograph No. 3). Apply blue dye to one end and red dye to opposite end. Place this tissue on microtome with peripheral edge up. Freeze and cut a frozen section and stain as above. This vertical section of the periphery is labeled 1B.
5. Repeat above procedure for each of the remaining blocks of tissue, i.e., a horizontal section from the subcutaneous base and a vertical section from the peripheral edge.

Associate Clinical Professor of Dermatology, L.S.U. School of Medicine, New Orleans, La.

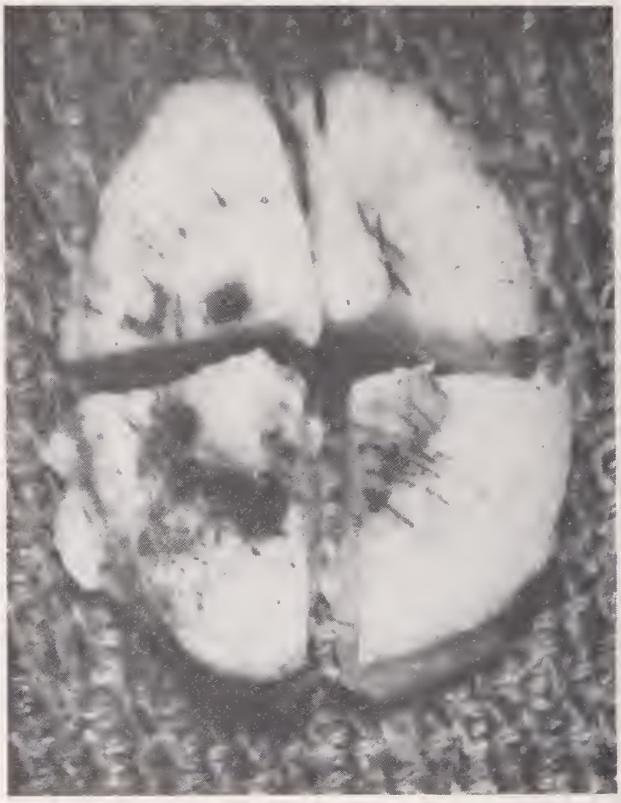
If any sections reveal tumor, reference is made to the surgical map and more tissue in this area is excised and studied in similar manner until all peripheral borders and base are free of tumor.

Figure 4 and photograph No. 4 present a small lesion requiring only 8 frozen sections—one section from *base* of each of the four tissue blocks (1A, 2A, 3A, 4A) and one section from the *periphery* of each tissue block (1B, 2B, 3B, 4B). Figure 5 and photograph No. 5 and Figure 6 present a larger lesion and require, therefore, more sections.

A method of histological examination to determine the adequacy of excision of surgically excised tumors of the skin has these advantages:

1. It is adapted to surgically excised tumors of the skin.
2. The staining of each frozen section is a 5 second one-step procedure.
3. Definitive surgical repair can be performed immediately after histological examination reveals the base and peripheral borders free of tumor.

The method is as follows: (The drawings will be followed by an illustrative photograph.)



Photograph No. 1

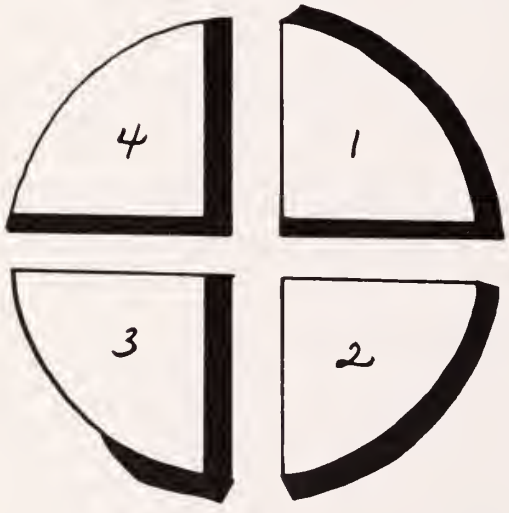


Figure 1. The excised quickly fixed tissue is cut into 1½-2 cm. diameter blocks.

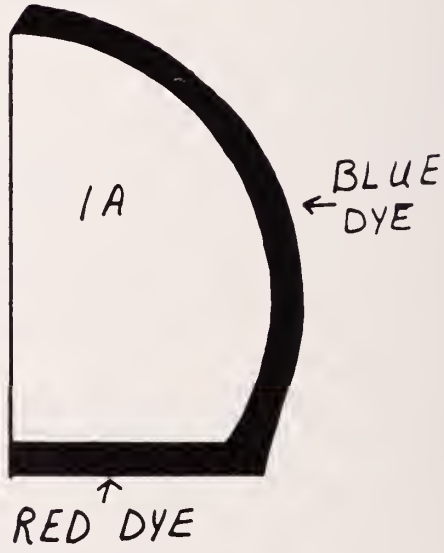


Figure 2. Blue dye is applied to one cut edge and red dye to an adjacent edge. Block is placed on microtome upside down (epidermis down) and frozen section from subcutaneous base is cut. This horizontal section of the base is marked 1A.



Photograph No. 2



Photograph No. 3

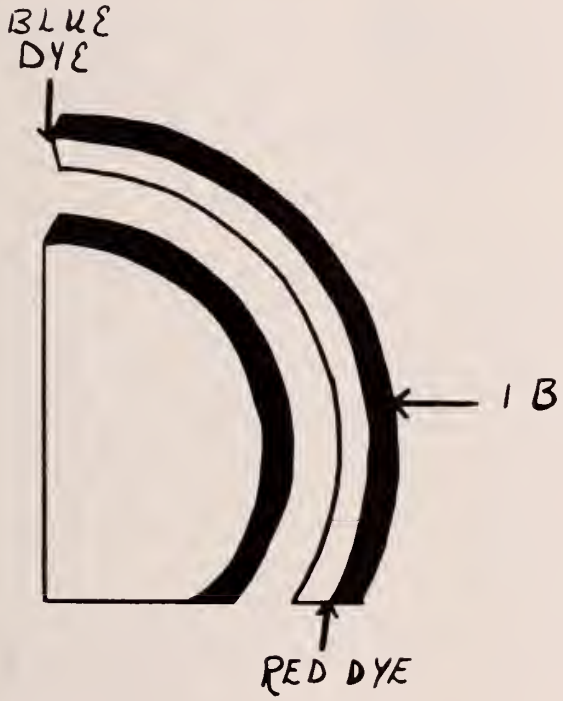


Figure 3. A vertical ribbon of tissues is cut from the peripheral edge. Red dye is applied to one end and blue dye to opposite end. Tissue is placed on microtome with peripheral *edge up. A frozen section is cut. This vertical section of the peripheral edge is marked 1B.*

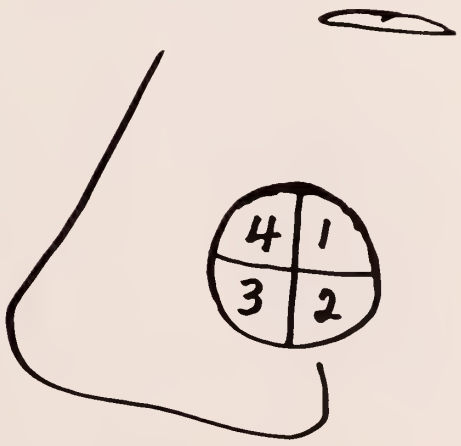


Figure 4. This small lesion requires only 8 frozen sections, i.e., one horizontal section from each base and one vertical section from each peripheral edge.



Photograph No. 4



Photograph No. 5

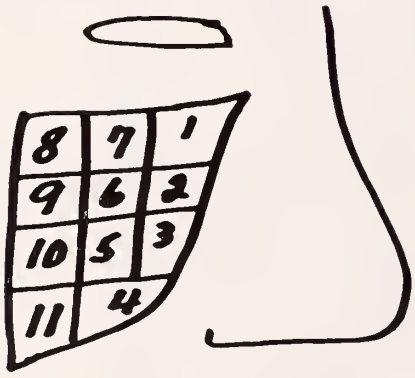


Figure 5

This represents a larger lesion excised. Note that blocks 1, 8, and 11 will require 2 vertical peripheral sections. Blocks 5 and 6 require no peripheral sections.

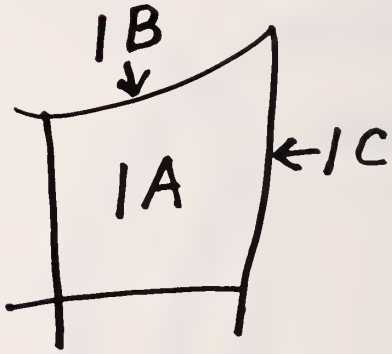


Figure 6

★★★

136 Marion Avenue (39648)

REFERENCES

1. Mohs, F. E.: Chemosurgery in Cancer, Gangrene, and Infections. Springfield, Charles C Thomas, 1956.
2. Thromovitch, T. A. and Stegman, S. J.: Microscopically Controlled Excision of Skin Tumors. Arch. Dermatol. 110:231-232, 1974.

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* **WARNING**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

Contraindications: Further use in progressive renal or hepatic dysfunction; hyperkalemia. Preexisting elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs. Routine use of diuretics in otherwise healthy pregnancy.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K^+ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy.** Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium® (triamterene, SK&F Co.), and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

SK&F CO., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

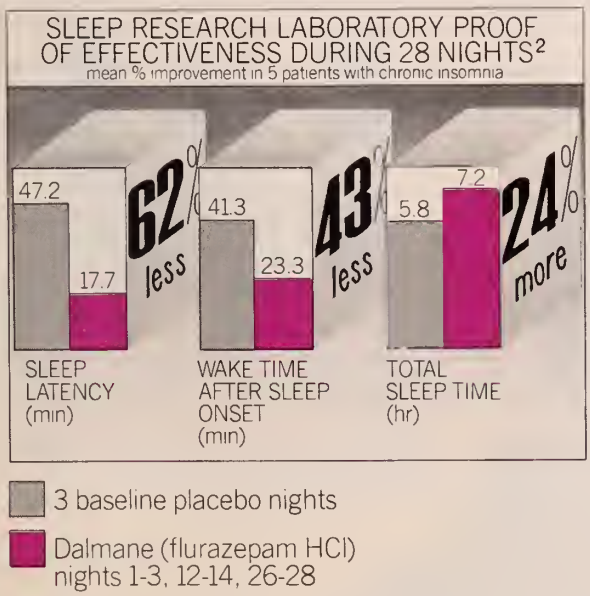

S
M
T
W
T
F
S
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

For insomnia that is a chronic problem...

Only Dalmane (flurazepam HCl) offers sleep laboratory proof of effectiveness for as long as 28 nights

Continued relief of insomnia in patients with chronic insomnia

Since insomnia is often transient and intermittent, the prolonged administration of a hypnotic is generally not necessary or recommended. But when insomnia is a chronic or recurring problem, continued effectiveness is as important as initial effectiveness. Results of a recently published sleep research laboratory study[1] demonstrated that, while pentobarbital lost effectiveness within two weeks, Dalmane maintained effectiveness for 28 consecutive nights. Similar 28-night results with Dalmane, displayed below, were obtained by a second sleep research group.[2] In previous studies,[3] both chloral hydrate and glutethimide began to lose effectiveness after several nights, while Dalmane maintained effectiveness throughout the 14 medication nights. Whether the problem is difficulty falling asleep, staying asleep or sleeping long enough, consider these results when selecting a sleep medication.



Patient benefits include relative safety, infrequent morning "hang-over"

Dalmane is well tolerated, seldom causing morning drowsiness or grogginess.[4] No increase in dosage is required for continued effectiveness from night to night.[1-3] Should Dalmane be used repeatedly, periodic blood counts and liver and kidney function tests should be performed. The usual adult dose is 30 mg *h.s.*, but 15 mg may suffice for some patients and is recommended as a starting dose for the elderly and debilitated to help preclude oversedation, dizziness or ataxia.

Continued relief of insomnia: One more good reason to specify

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.

whenever a hypnotic is needed

ROCHE

Please see following page for a summary of product information.

Objective proof: continued insomnia relief without increasing dosage...[1,2]

Dalmane® (flurazepam HCl) Ⓒ IV

Objectively proved in the sleep research laboratory...

during 28 consecutive nights of administration:

- ☐ **effectiveness with a single 30-mg *h.s.* dose, maintained**
- ☐ **rapid sleep induction, maintained**
- ☐ **sleep for 7 to 8 hours, on average, maintained**
- ☐ **less time awake during the night, maintained**

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

Usage in Pregnancy: **Several studies of minor tranquilizers (chlordiazepoxide, diazepam, and meprobamate) suggest increased risk of congenital malformations during the first trimester of pregnancy. Dalmane, a benzodiazepine, has not been studied adequately to determine whether it may be associated with such an increased risk. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, limit initial dosage to 15 mg to preclude oversedation, dizziness and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

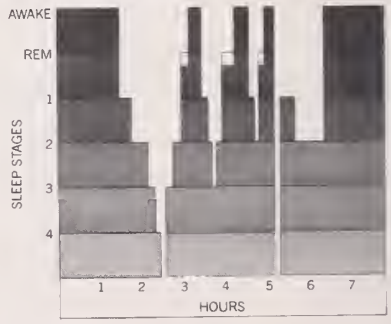
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



REFERENCES:

1. Kales A, *et al*: *Clin Pharmacol Ther* *18*:356-363, Sep 1975
2. Dement WC, *et al*: Long-term effectiveness of flurazepam 30 mg *h.s.* on chronic insomniacs. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, Jun 30-Jul 4, 1975
3. Kales A, *et al*: *Arch Gen Psychiatry* *23*:226-232, Sep 1970
4. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

For all common types of insomnia



ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Radiological Seminar CLXV: The Passing of the General Radiologist

ROBERT D. SLOAN, M.D.
Jackson, Mississippi

THE ERA OF THE general radiologist, that physician trained in and supposedly competent to practice both diagnostic and therapeutic radiology, is coming to an end. The official death knell was sounded in a recent memo from the Division of Medical Education of the American Medical Association, stating in part that "Effective July 1, 1976, no applications for approval from new residency programs in general radiology will be accepted. Effective July 1, 1979, the approval of all programs in general radiology will be withdrawn. No new residents are to be appointed in approved general radiology programs to first year positions after July 1, 1976; . . . "

Translated, this means that after July 1, 1979, residents coming out of training programs into the market place of the clinical practice of radiology will have been trained in either diagnostic or therapeutic radiology, but not both modalities.

Why has this situation developed? It is simply that radiology, along with other medical disciplines, has been caught up in the tremendous explosion of scientific knowledge and its accompanying technical and procedural capabilities. Much of this expansion has occurred during the professional lifetime of this author. Twenty to 30 years ago the only training programs available were in so-called general radiology, and it was truly possible for one individual to have some degree of competence in all aspects of the field. Today this is no longer possible, and in fact it is now impossible for any single radiologist to be truly knowledgeable in all areas of diagnostic radiology. Subspecialty interests, as in pediatric radiology, neuroradiology, vascular radiology, nuclear medicine and now ultrasound and computerized axial tomography are already well established in radiology departments of any real size, with individual radiologists devoting their major time efforts to these fields. The separation of diagnostic and therapeutic training programs first started in the larger urban centers of this country, and it is of some interest that the radiation therapists have been just as adamant over the need for separation as have the diagnostic radiologists.

What are the implications in this change for Mississippi? One may argue that there is still a very real need for a generalist type radiologist in a predominantly rural environment such as ours, and that this trend toward further specialization is contrary to the current national emphasis on the need for less specialization, but such arguments are now academic. The Department of Radiology at the University Medical Center has had no choice but to establish a so-called straight diagnostic training program, and in fact the new residents who started their training in July 1976 are in such a program. The establishment of an accompanying straight training program in therapeutic radiology, in contrast, does not seem feasible at this time for various reasons, and countrywide there continues to be a shortage of therapeutic radiologists.

As the current group of practicing general radiologists gradually retire or pass on to their just rewards (wherever or whatever that may be), they will be replaced by a new breed of radiologists, some of whom are already on the scene. These individuals will have received a minimum of three years of training in the various general and subspecialty aspects of diagnostic radiology, and overall they will be well

Sponsored by Mississippi Radiological Society.
From the Department of Radiology, University of Mississippi Medical Center, Jackson, Ms.

equipped to handle the diagnostic needs of the state. This is not to imply, of course, that there may not be some supply and demand problems, or that smaller community hospitals with limited diagnostic capabilities will not have difficulty in obtaining radiologic coverage.

Of more concern, however, would appear to be the impact on therapeutic radiology within the state. It is not the purpose of this article to discuss this problem in any detail, but it does not take much imagination to appreciate that not too far down the road there will be no certified radiologist to operate the smaller community therapeutic facilities now in existence in Mississippi. Some would argue that these facilities should be phased out anyway, because of their very real limitations, and others might argue that radiation therapy itself may well be phased out as a method of treatment for malignancy by chemotherapeutic or other modalities. At this point in time however, it would seem that malignancy will continue to be of increasing significance as a medical problem, and that there will be need for all currently known modalities in its treatment for some time to come. If the smaller treatment centers become inoperative because of a lack of therapists or inadequate facilities, will the larger centers in the state be able to take up the slack? It is apparent that they can not achieve this as they are now constituted. At the present time there are only three full time radiation therapists practicing in the state, two of these being in Jackson, with limited expansion capabilities. It would seem that the time has come for the exploration of possible solutions to the problem of providing effective radiation therapy for the population of Mississippi, and ideally this evaluation should be conducted on a statewide basis. The problems are formidable, and the hour is already late. ★★★

2500 N. State Street (39216)



Warmest thoughts and
best wishes for a wonderful
holiday season and a very
happy new year!
—MSMA staff

Counsel to Authors

THE JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, Miss. 39216, in original and at least one duplicate copy. They must be typewritten double spaced on 8½ by 11-inch white bond paper with a standard typewriter. **Brief manuscripts will be given preference.**

The author is responsible for all statements made in his work, including changes made by the manuscript editor. Manuscripts are received with the understanding that they are not under simultaneous consideration by any other publication and have not been previously published. All manuscripts will be acknowledged, and while those rejected are generally returned to the author, the JOURNAL is not responsible in event of loss. Manuscripts accepted for publication become the property of the JOURNAL and are copyrighted by the association when published. They may not be published elsewhere without written release and permission from both the JOURNAL and the author.

All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus,* volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made after proof sheets are received by the JOURNAL.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for illustration engravings not exceeding four column inches per printed page.

Illustrations must be numbered and cited in the text. Legends, not exceeding 40 words and preferably shorter, must accompany each illustration, typed double spaced on separate sheets. The following information should appear on a gummed label affixed to the back of each illustration: Figure number, manuscript title, author's name, and arrow indicating top of the illustration.

In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

A thesis summary of 75 to 100 words must accompany each manuscript.

Reprints may be obtained at cost plus shipping charges from the association and **should be ordered prior to publication.** The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. —*The Editors.*



The President Speaking

"Legislation in 1977"

LYNE S. GAMBLE, M.D.
Greenville, Mississippi

"ALL YOUR STRENGTH IS IN YOUR UNION.
ALL YOUR DANGER IS IN DISCORD"
Henry Wadsworth Longfellow

THE MISSISSIPPI LEGISLATURE will soon be in session again. The MSMA House of Delegates has recommended that the component societies hold "Legislators Night." It is imperative that we meet with our legislators on a regular basis to discuss with them the growing number of health matters with which both they and we are concerned. Your legislator doesn't particularly care what Lyne Gamble or our state office staff in Jackson think about a bill. He does care what you think! You may rest assured that others are talking to him and more often than not, what they are talking to him about concerns you and the future of our profession.

The 1977 MSMA legislative program supports proposals which would:

(1) Provide for the restriction, supervision, or revocation of the license of any physician for professional incompetency or medical malpractice after all rights of appeal have been exhausted. Give statutory authority for any hospital, upon recommendation of its medical staff, to restrict the privileges of any member of such staff.

(2) Provide statutory immunity from liability for any disciplinary actions taken by a "peer review committee" against another physician provided such actions are taken in good faith and without malice. Also provide immunity to any individual who furnishes information concerning the conduct of a physician to a hospital or medical society peer review committee.

(3) Require that before any malpractice lawsuit is filed, the alleged claim must be reviewed by a panel of one attorney and three physicians and that the panel's opinion regarding the merits of the claim can be introduced in evidence by either party if a suit is subsequently brought. (Statistics show that approximately 70 per cent of the claims against Mississippi physicians do not result in any payment to the patient, yet these claims are expensive to handle and these large administrative expenses mean higher premiums. By requiring that each claim be reviewed by a panel of attorneys and physicians before suit could be filed, many of these non-meritorious "nuisance" suits could be weeded out. Additionally, the panel could also provide expert testimony in valid cases of medical negligence.)

(4) Permit introduction of evidence concerning collateral resources, or payments which an injured patient has received from

(Continued on page 359)

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XVII, NUMBER 12
DECEMBER 1976



EDITORIALS

The New President and Medicine

A new president has been elected and no doubt a new direction in big government will begin. While our president-elect has been quite evasive on many issues, he seemed very intent on compulsory National Health Insurance. The medical profession in general is soundly against this approach. It may *well* mark the end of the free enterprise system as pertains to medicine and result in devastation as evident in England.

There are hopeful signs, however. Carter does state that he hopes to accomplish this when we can afford it. If he balances the budget as he has suggested that he will, then I believe we have nothing to fear from total health insurance.

Perhaps our newly elected president is a man of vision and will exhibit constructive leadership. Our nation is in dire need of such a man. A democratic president with a predominantly democratic congress is certainly in a favorable position for healthy change.

W. Moncure Dabney, M.D.
Editor
Crystal Springs, MS

The President Speaking

(Continued)

other sources, such as disability payments, accident and health insurance payments, or Medicare or Medicaid benefits. (Evidence of these other payments or benefits are not allowed to be introduced now; consequently, the jury might award a judgment which amounts to double compensation for the patient's injuries.)

(5) Provide that a written agreement between a patient and physician or a patient and hospital to arbitrate any disputes that may arise out of that patient's care and treatment shall be valid, irrevocable, and binding.

The MSMA opposes two bills which are likely to be introduced:

(1) Would permit a pharmacist to substitute a generic equivalent drug for a brand name prescription. This bill would repeal our anti-substitution law which authorizes a pharmacist to dispense only the product prescribed by a physician or dentist and instead permits the pharmacist to substitute a generic drug unless the physician vetoes such a substitution in writing. This would not be in the patient's best interest or the interest of quality health care. The physician must maintain control over his patient's drug therapy.

(2) Would authorize optometrists to diagnose and utilize topical medications. MSMA is opposed to the diagnosis of diseases and the use of medications by any non-medically trained persons. This bill was passed in the Senate last year and came very close to passage in the House.

PRESIDENT'S PAGE / Gamble

On May 20, 1976, optometry became a new medical specialty in the state of West Virginia. After the House and the Senate overrode the governor's veto, the definition of optometry was broadened to include the use of both diagnostic and therapeutic agents. Since 1971, Rhode Island, Pennsylvania, Delaware, Louisiana, Maine, Oregon, and Tennessee have enacted legislation authorizing optometrists to use topical diagnostic medications. The optometry problem is but a part of a much larger and much more profound threat to the medical profession.

An attack against one segment of medicine is an attack against all. I urge you to communicate with your legislators in the most effective way possible concerning these matters. ★★★

Medico-Legal Brief

PHYSICIAN NOT LIABLE FOR NURSE'S NEGLIGENCE IN GIVING INJECTION

A licensed vocational nurse who injured a patient's sciatic nerve while giving him a penicillin injection was not a "borrowed employee" of the patient's physician, a Texas appellate court ruled.

Suffering from bronchial pneumonia, the patient sought medical assistance from the physician, who had him admitted to a county hospital. A licensed vocational nurse employed by the hospital gave the patient an injection of penicillin. The patient complained of pain immediately afterwards, and the physician diagnosed the condition as damage to the sciatic nerve.

Paralysis of his left side set in, and he was treated by a neurosurgeon. When he failed to respond to treatment by the neurosurgeon, he was admitted to another hospital for nerve repair surgery. After this surgery, he still complained of pain and discomfort in his lower right extremity. He was discharged in a few weeks, but he later entered a VA hospital for further treatment. He committed suicide nine months later, shortly after his discharge from the VA hospital and after filing a malpractice suit.

In the suit against the physician, the hospital and the county, the estate sought $385,000 in damages. A trial court granted summary judgment for the hospital and the county on grounds of governmental immunity. A jury then rendered a verdict for the physician, and the patient's estate appealed.

On appeal, the court said that the nurse who gave the injection was not a "borrowed employee" of the physician. The nurse was a general employee of the hospital and performed routine acts in obedience to the physician's instructions. The court said that a physician is not liable for negligence in treatment prescribed by him but administered by floor nurses in the regular course of their hospital duties. The trial court properly let the jury decide whether the nurse was performing a routine act in giving the penicillin injection. The jury found that the nurse was not a "borrowed employee" of the physician.

Finally, the court said that the trial court had properly granted judgment for the hospital and the county. The malpractice claim arose before the Texas legislature permitted suits against the state and counties. Since governmental immunity was still in existence at the time of the injection, the judgment for the hospital and county was properly granted.

The trial court's decision was affirmed.—*Miller v. Hood,* 536 S.W.2d 278 (Tex.Ct. of Civil App., April 22, 1976; rehearing denied, May 13, 1976)



PERSONALS

ROLANDO T. ABANGAN and AIDA A. MALONZO of Meridian announce the relocation of their offices from St. Joseph Medical Plaza to 1304 18th Avenue for the practice of neurological surgery and ob-gyn, respectively.

LEONARD D. BALL of Gulfport has qualified as a charter member of the Medical Alumni Guardian Society of the University of Mississippi Foundation.

WILLIAM A. BILLUPS, JR., of Meridian was the guest speaker for the fall meeting of the East Mississippi Medical Society. He discussed the prevention of strokes.

ELDON L. BOLTON of Biloxi ran for re-election as election commissioner of Beat 5, Harrison County.

LOREN D. BRELAND of Crystal Springs announces the relocation of his office to 223 West Railroad Avenue.

A. WALLACE CONERLY of Jackson and UMC is the recipient of an award from the Mississippi Society of the American Association for Respiratory Therapy. The award was presented in appreciation for Dr. Conerly's contributions to the society and respiratory health care in Mississippi.

LEWIS EDWIN HATTEN of Hattiesburg and ROBERT REX APPLEWHITE of Laurel have become fellows of the American College of Surgeons.

Lucien Hodges of Jackson was presented a plaque for alumnus of the year at homecoming ceremonies at Copiah-Lincoln Junior College in Wesson.

Andrew K. Martinolich of Bay St. Louis was elected chief of the medical-dental staff at Memorial Hospital in Gulfport. Ronald L. Brown of Gulfport was elected vice chief of staff and W. K. Stewart of Pass Christian was named secretary-treasurer.

Charles D. Miles of Columbus has been elected to fellowship in the American College of Obstetricians and Gynecologists.

Francis Morrison of Jackson and UMC delivered an invited lecture on modern trends in blood banking and the role of the council of community blood centers to the Texas Association of Blood Bank Administrators in San Antonio.

Thomas Purser, III, of Laurel was presented with a plaque at the medical staff meeting held at South Mississippi State Hospital in appreciation of his service as medical director of the hospital for 1975-76.

William B. Robinson has associated with the Gulf Coast Surgical and Diagnostic Center, P.A. for the practice of psychiatry at Medical Plaza, Vancleave Road, Ocean Springs.

Francis J. Selman, Jr., of Pascagoula and Robert Frank Carter of Biloxi have been named fellows of the American College of Surgeons.

Bennett Smith and Frank Dement of Hattiesburg discussed diabetes from birth to adolescence for the Hattiesburg meeting of the American Diabetes Association, Mississippi affiliate.

Joseph E. Swanton has set up practice in Senatobia and will move into Norfleet Medical Building when it is completed. He specializes in obstetrics-gynecology.

David H. Thornhill of Gloster has been named parade marshal for the 1976 Gloster Christmas parade.

Dr. and Mrs. Dan R. Thornton, Jr., of Meridian presented a framed needlepoint seal, designed and worked by Mrs. Thornton, to the American College of Ob-Gyn to commemorate the ACOG's 25th anniversary.

POSTGRADUATE CALENDAR

Jan. 10-11, 1977

Newborn Resuscitation
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine, Department of Pediatrics, Division of Newborn Medicine, the School of Nursing, and the University Medical Center Division of Continuing Health Professional Education

Coordinator:
Gwendolyn Bussa, M.N., assistant professor of nursing, the University of Mississippi School of Nursing

Open to physicians, RNs, and respiratory therapists, the two-day course will emphasize the manual skill of resuscitation with lectures and practice. UMC faculty will stress management of the mechanical and pharmacologic needs of the resuscitated newborn, and how to identify the newborn in need of resuscitation. Enrollment is limited to six. Other sessions are planned for Feb. 7-8 and May 23-24 at the Medical Center. Fee: $50. Credit: 15 contact hours, 1.5 CEU, Category I, AMA; AAFP.

Jan. 13-14, 1977

Newborn Ventilation
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine, Department of Pediatrics Division of Newborn Medicine, the School of Nursing, and the University Medical Center Division of Continuing Health Professional Education

Coordinator:
Gwendolyn Bussa, M.N., assistant professor of nursing, University of Mississippi School of Nursing

UMC faculty will teach anatomy and physiology, indications, and practical problems of newborn ventilation in this two-day course for physicians, RNs, and respiratory therapists. Emphasis is on initiation, maintenance, and nursing care of the newborn on artificial ventilation. Another session is planned for May 26-27 at the Medical Center. Fee: $50. Credit: 14 contact hours, 1.4 CEU, Category I, AMA; AAFP.

The University of Mississippi Medical Center Division of Continuing Health Professional Education offers intensive refresher courses to meet physicians' clinical practice needs in the specialties most requested. Mississippi Regional Medical Program partially supports the series open to all physicians. Intensive courses are eligible for AMA Physician Recognition Award, Category I, credit. Enrollment is limited, and applications are accepted in the order received. All correspondence about intensive and other courses should be addressed to Continuing Education, University Medical Center, 2500 North State Street, Jackson, MS 39216.

FUTURE CALENDAR

Feb. 7-8, 1977, UMC
NEWBORN RESUSCIATION

Feb. 9-11, 1977, UMC
NEWBORN CARE FOR PHYSICIANS

Feb. 7-9, 1977, UMC
UROLOGY INTENSIVE COURSE

Feb. 14-18, 1977, UMC
NEPHROLOGY INTENSIVE COURSE

Feb. 17, 1977, McComb
EARLY DETECTION OF HEAD AND NECK CANCER

Unlicensed Practice Is Charged

A Tupelo man has been charged with practicing medicine without a license by State Attorney General A. F. Summer and the Mississippi State Board of Health in a complaint filed with Lee County Chancery Court Clerk Jerry Clayton.

The complaint seeks an injunction against Ralph Hughes, 819 Harrison Street, charging him with "performing acts constituting the practice of medicine as a profession and holding himself out to the public as engaging in the practice of medicine . . . and the practice of osteopathic medicine without licensure."

The complaint, entered last week, charges Hughes "is engaged in suggesting, recommending, prescribing and directing for the use of persons drugs, medicines, vitamins, food supplements and other similar preparations as well as appliances . . . for the diagnosis, cure, relief or palliation of ailments and diseases. . . ."

The injunction asks for discovery permission to determine "the name and description of said drugs, vitamins, food supplements and other preparations being dispensed. . . ."

Illegal Drug Charges Made Against Physicians

As JOURNAL MSMA went to press, the Federal Drug Enforcement Agency had arrested several Mississippi physicians on charges of illegally distributing controlled drugs and reports were that several more physicians were still under investigation.

The arrests follow several months of investigation by agents of the DEA. The indictment against one of the physicians charges that he sold drug prescriptions to federal agents on three occasions during April and May of this year.

Mississippians Participate in Pediatric Pulmonary Course



Mississippi physicians participating in the recent 2nd Annual LAMOT Pediatric Pulmonary Conference held in Shreveport, LA, are Dr. Wilfred Cole, associate clinical professor of pediatrics; Dr. Suzanne Miller, assistant professor of pediatrics and conference chairman; and Dr. Linda Walters, assistant professor of pediatrics of University Medical Center, Jackson. Sponsored by Lung and Thoracic Societies of Louisiana, Arkansas, Mississippi, Oklahoma and Texas, the LAMOT provides postgraduate opportunities to specialists in internal medicine, family practice, radiology, in addition to general pediatrics and pulmonary pediatric practice. LAMOT, made possible by Christmas Seal contributions and Memorial Gift donations, is endorsed by the American Thoracic Society.

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, June 26-July 1, Dallas. Clinical Convention, Dec. 4-8, 1976, Philadelphia. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

La.-Miss. O. and O. Society, April 28-May 1, 1977, Point Clear, Ala. Arthur Hays, M.D., Secy., 3017 13th St., Gulfport 39501.

STATE AND LOCAL

Mississippi Academy of Family Physicians, Annual Meeting, July 7-10, 1976, and July 6-9, 1977, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 109th Annual Session, May 2-5, 1977, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Smith, Yazoo.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Gerald A. Smith, Secy., P.O. Box 128, Sumner 38957. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. A. K. Martinolich, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Reginald P. White, Secy., East Mississippi State Hospital, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, April, June, August, October, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., Jefferson Davis Memorial Hospital, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. D. Stanley Hartness, Jr., Secy., 314 Adams St., Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Lee H. Rogers, Secy., 610 Brunson Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, October. Cherie Friedman, Secy., 1004 Jackson Ave., Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. James H. Sams, Secy., P.O. Box 1381, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, May, July, September, November. Dewey Laner, Secy., Doctors Plaza, Suite 206, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. John L. Smith, Secy., No. 1 Medical Blvd., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

When the same patient makes your office a merry-go-round of somatic complaints



Adapin® (doxepin HCl) may be what she needs

I'm so jumpy, I'm afraid of my own shadow.

I have these headaches almost everyday—I can't understand it, I never used to have them.

Doctor, is it right that I should be so constipated all the time?



Anxiety/depression could be the basis of her somatic complaints
You know the type. She's got a new symptom every visit. And there's never any physiological basis. When you see the chronic "complainer," a diagnosis of depression may be considered . . . and an Rx for Adapin.

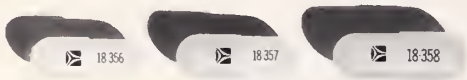
Adapin allays anxiety; improves sleep; brightens the outlook
Adapin can often help the chronic "complainers" get positively reinvolved with life. Adapin almost immediately allays symptoms of anxiety and tension. And from the earliest days it makes it easier for the patient to get to sleep—helps her stay asleep longer. And where there is underlying depression, Adapin usually begins to lift it within three or four weeks.

Please see following page for prescribing information

ADAPIN®
(Doxepin HCl)
Capsules, 10 mg, 25 mg and 50 mg

PENNWALT

ADAPIN®
(Doxepin HCl)



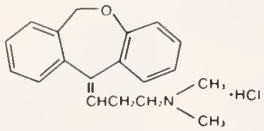
10 mg. **25 mg.** **50 mg.**

Usual optimum dosage is 75 to 150 mg. per day.

Prescribing information:

DESCRIPTION

Adapin (doxepin HCl) is an isomeric mixture of N, N-dimethyl-dibenz(b,e) oxepin- $\Delta^{11(6H)}$, γ propylamine hydrochloride.



ACTIONS

Adapin has a variety of pharmacological actions with its predominant action on the central nervous system. While its mechanism of action is not known, studies have demonstrated that it is neither a monoamine oxidase inhibitor nor a primary stimulant of the central nervous system.

INDICATIONS

In controlled clinical evaluations, **Adapin** has shown marked antianxiety and significant antidepressant effects. **Adapin** has been found to be well tolerated even in elderly patients.

Adapin is indicated for the treatment of patients with:

1. Psychoneurotic anxiety and/or depressive reactions.
2. Mixed symptoms of anxiety and depression.
3. Anxiety and/or depression associated with alcoholism.
4. Anxiety associated with organic disease.
5. Psychotic depressive disorders including involutional depression and manic-depressive reactions.

Target symptoms of psychoneurosis that respond particularly well to **Adapin** include: anxiety, tension, depression, somatic symptoms and concerns, insomnia, guilt, lack of energy, fear, apprehension and worry.

Because **Adapin** provides antidepressant as well as antianxiety effects, it is of particular value in patients in whom anxiety masks depression. Patients who have not responded to other antianxiety or antidepressant drugs may benefit from **Adapin.**

In a large series of patients systematically observed for withdrawal symptoms, none were reported—a finding which is consistent with the virtual absence of euphoria as a side effect and the lack of addictive potential characteristic of this type of chemical compound.

CONTRAINDICATIONS

Because **Adapin** has an anticholinergic effect, it is contraindicated in patients with glaucoma or a tendency toward urinary retention.

Use of **Adapin** is contraindicated in patients who have been found hypersensitive to it.

WARNINGS

Usage in Pregnancy—Adapin has not been evaluated in pregnant patients. Therefore, it should not be used during pregnancy unless, in the judgment of the physician, it is essential to the welfare of the patient.

In animal reproduction studies of **Adapin,** gross and microscopic examination of the offspring gave no evidence of drug-related teratogenic effect. Following doses of up to 25 mg./kg./day for 8 to 9 months, no changes were observed in the number of live births, litter size, or lactation. A decreased rate of conception was observed when male rats were given 25 mg./kg./day for prolonged periods—an effect which has occurred with other psychotropic drugs and has been attributed to drug effect on the central and/or autonomic nervous systems.

Usage in Children—The use of **Adapin** in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors—Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with **Adapin.** The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

PRECAUTIONS

Drowsiness may occur with **Adapin (doxepin HCl);** therefore, patients should be warned of its possible occurrence and cautioned against driving a motor vehicle or operating hazardous machinery while taking the drug.

Patients should also be cautioned that the effects of alcoholic beverages may be increased.

Since suicide is an inherent risk in depressed patients and remains a risk through the initial phases of improvement, depressed patients should be closely supervised.

Although **Adapin** has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Compounds structurally related to **Adapin** can block the effects of guanethidine and similarly acting compounds. However, at the usual clinical dosages, 75 mg. to 150 mg. per day, **Adapin** has been given concomitantly with guanethidine without blocking its antihypertensive effect. But at dosages of 300 mg. per day or higher, **Adapin** has exerted a significant blocking effect.

Adapin, like other structurally related psychotropic drugs, potentiates norepinephrine response in animals. But this effect has not been observed with **Adapin** in humans, which is in accord with the low incidence of tachycardia reported clinically.

ADVERSE REACTIONS

Anticholinergic Effects: Dry mouth, blurred vision and constipation have been reported. These are usually mild, and often subside as therapy is continued or dosage reduced.

Central Nervous System Effects: Drowsiness has been observed. It usually occurs early in the course of therapy and tends to subside as therapy continues. (See Dosage and Administration section.)

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported adverse effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects (such as increased sweating), weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

DOSAGE AND ADMINISTRATION

In most patients with mild to moderate anxiety and/or depression: 10 mg. to 25 mg. t.i.d. to start. A starting dosage of 10 mg. t.i.d. for a period of four days may reduce the initial drowsiness experienced by some patients, and may be tried in cases where drowsiness is clinically undesirable. Decrease or increase the dosage at appropriate intervals according to individual response. Usual optimum dosage is 75 mg. to 150 mg. per day.

In some patients with mild symptomatology or emotional symptoms accompanying organic disease, dosage as low as 25 mg. to 50 mg. per day has provided effective control.

In more severe anxiety and/or depression: 50 mg. t.i.d. may be required to start—if necessary, gradually increase to 300 mg. per day. Additional effectiveness is rarely obtained by exceeding 300 mg. per day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

OVERDOSAGE

Symptoms—An increase of any of the reported adverse reactions, primarily excessive sedation and anticholinergic effects such as blurred vision and dry mouth. Other effects may be: pronounced tachycardia, hypotension and extrapyramidal symptoms.

Treatment—Essentially symptomatic; supportive therapy in the case of hypotension and excessive sedation.

HOW SUPPLIED

Each capsule contains doxepin, as the hydrochloride: 10 mg. (NDC 0018-0356), 25 mg. (NDC 0018-0357) and 50 mg. (NDC 0018-0358) capsules in bottles of 100, and 1000.

Brighter days ahead for your psychosomatic complainers



PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603

Mississippi State Medical Association Auxiliary

After changing our name and by-laws so that husbands of women physicians could join the Auxiliary, we have had several men become members. We feel that any spouse of a Mississippi doctor will want to support the medical profession through medical auxiliary.

The Auxiliary is proudly displaying a new seal. It is our first. Mrs. Edward Hill of Hollandale designed the seal using our long-standing logo.

The Auxiliary has a lovely new history of our first 50 years—*The Torchbearers*. We hope that this history will become a part of the library of each Mississippi doctor. Mrs. Charles Thompson of Columbia headed the large project of researching and writing the history.

This year we have started a collection of medical antiques. If you have old instruments, furnishings or publications, we would love to have these and promise that they will receive perpetual care. Contact Mrs. Donald Barraza, 8 Adams Circle, Natchez. We feel that the medical auxiliary is a most appropriate place for these.

At this special "giving" time of the year, we hope that you are aware of how freely our doctors' spouses give of their time and talents to service projects throughout the year. Members are actively raising funds for AMA-ERF, working with immunization programs and striving to meet health needs that exist in our communities across the state. We are currently working on two new projects. One involves a personal visit with our legislators. Mrs. John Estess of Hollandale is our state legislative chairman. The other is an education program on organ donations. Mrs. George V. Smith of Jackson will serve as state chairman for this project.

Through our large active medical auxiliary, we hope to give the medical profession strong support. Also, we hope to demonstrate our desire to work for the things that you, our Mississippi doctors, believe in and work for.

Have a happy Holiday Season!

Imogene Brown
(Mrs. W. A. Brown, Jr.)
President, MSMA Auxiliary

NEW MEMBERS

BOONE, WALTER T., Jackson. Born Marks, MS, Dec. 28, 1939; M.D., University of Mississippi School of Medicine, Jackson, 1965; interned Union Memorial Hospital, Baltimore, MD, one year; medicine residency, same, 1966-70; gastroenterology residency, Yale, New Haven, Conn., 1973-75; elected by Central Medical Society.

CALVERT, WILLIAM E., Bay St. Louis. Born McComb, MS, Feb. 28, 1942; M.D., University of Mississippi School of Medicine, Jackson, 1967; interned Mobile General Hospital, Mobile, AL, one year; elected by Coast Counties Medical Society.

DAVIS, WILLIAM M., Ocean Springs. Born Dover, DE, Jan. 30, 1943; M.D., University of Texas Medical Branch, Galveston, TX, 1969; interned Wilford Hall USAF Medical Center, Lackland AFB, TX, one year; surgery residency, Travis AFB, CA, 1970-74; plastic surgery residency, Lackland AFB, TX, 1974-76; elected by Singing River Medical Society.

DEGROOTE, J. W., Pascagoula. Born Humboldt, IA, Aug. 2, 1936; M.D., University of Iowa College of Medicine, Iowa City, 1962; interned Minnesota General Hospital, one year; internal medicine residency, University of Alabama, Birmingham, 1968-72; fellowship in endocrinology, diabetes, and metabolism, 1972-73; elected by Singing River Medical Society.

GODSEY, JOHN W., Biloxi. Born Richmond, VA, June 10, 1939; M.D., Bowman Gray School of Medicine, Winston-Salem, NC, 1967; interned Presbyterian Hospital, San Francisco, CA, one year; radiology residency, Shands Teaching Hospital, University of Florida, Gainesville, one year; radiology oncology residency, University of California Medical Center, San Francisco, 1969-71; elected by Coast Counties Medical Society.

HENRY, D. CHAN, Jackson. Born Meridian, MS, Nov. 30, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned Spartanburg General Hospital, Spartanburg, SC, one year; elected by Central Medical Society.

HUGHES, JAMES L., Jackson. Born Greenville, SC, Sept. 21, 1937; M.D., Bowman-Gray School of Medicine, Winston-Salem, NC, 1963; interned Roosevelt Hospital, NY, one year; orthopedic surgery, same, 1964-65; orthopedic surgery residency, Johns Hopkins, Baltimore, MD, 1967-70; fellowship, orthopedic surgery, University of Basel, Switzerland, 1970-71; elected by Central Medical Society.

LOWE, ROBERT RAY, JR., Jackson. Born Blytheville, AK, Jan. 7, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned Roanoke Hospital, VA, one year; surgery residency, UMC, Jackson, MS, 1974-75; elected by Central Medical Society.

MITCHELL, JOSEPH R., Gulfport. Born Chicago, IL, Aug. 9, 1938; M.D., Meharry Medical College School of Medicine, Nashville, TN, 1964; interned Santa Clara County Hospital, San Jose, CA, one year; ob-gyn residency, Kapiolani Maternity Gynecology Hospital, Honolulu, HI, July 1968-July 1971; ob-gyn residency, L. A. USC Medical Center, Los Angeles, CA., 1971-72; elected by Coast Counties Medical Society.

SAMS, WILLIAM C., III, Gulfport. Born San Francisco, CA, Dec. 29, 1939; M.D., University of Texas, Southwestern, Dallas, 1970; interned Baptist Memorial Hospital, Memphis, TN, one year; ophthalmogy residency, University of Tennessee, Memphis, 1971-74; elected by Coast Counties Medical Society.

SANFORD, ROBERT A., Jackson. Born Torrington, CT, June 23, 1941; M.D., University of Arkansas School of Medicine, Little Rock, 1967; interned Minnesota Medical Center, Minneapolis, one year; surgery and neurosurgery residency, University Medical Center, Jackson, MS, 1968-73; elected by Central Medical Society.

YAMASHIRO, EMI, Gulfport. Born Sanger, CA, Oct. 2, 1932; M.D., Meharry Medical College School of Medicine, Nashville, TN, 1966; interned Orange County General Hospital, Orange, CA, one year; ob-gyn residency, Honolulu, HI, 1967-70; fellowship in adolescent ob-gyn and pediatric gynecology, Los Angeles, July 1971-June 1972; elected by Coast Counties Medical Society.

DEATHS

HAND, WILLIAM F., Jackson. Born Ellisville, MS, Oct. 6, 1902; M.D., Tulane University School of Medicine, New Orleans, LA, 1927; interned French Hospital, New Orleans, LA., one year; residency in surgery, Charity Hospital, New Orleans, LA, June 1927-June 1928 and Nov. 1929-Sept. 1930; emeritus member of MSMA and AMA; died Oct. 31, 1976, age 74.

Executive Director Phil Laird Reports on the Mississippi Health Systems Agency, Inc.

(Editor's Note: JOURNAL MSMA recently had the pleasure of interviewing Mr. Phil Laird, Executive Director of the Mississippi Health Systems Agency, Inc. This report is from that interview.)

Phil Laird, the director of Mississippi's new Health Systems Agency, is a professional health planner. Laird, who received his B.S. from Millsaps College and Masters in Public Health from Tulane University, has been a part of the Mississippi health care scene since 1966. Subsequent to graduating from Millsaps and prior to attending Tulane he worked in the Disease Control Unit of the Mississippi State Board of Health from 1966-70. Upon graduating from Tulane, he joined the Governor's Office for Comprehensive Health Planning in 1972 and became acting director of that agency in 1974. In August of this year he was named executive director of the Mississippi Health Systems Agency, Inc.

Public Law 93-641, The National Health Planning and Resources Development Act of 1974, establishes and funds local health system agencies to generally determine and plan for local health needs and health resources. Costs and accessibility to health services will be important considerations in this process. The Health Systems Agency will eventually have review and approval authority over several federal health grant programs such as the Community Mental Health Centers Act and will adminster a "Certificate of Need Requirement" for capital and service improvements to hospitals and nursing homes. Mississippi Health Systems Agency, Inc. has received a grant of $658,680.00 for first year funding under Public Law 93-641.



Phil Laird, MHSA Director

Laird reports that his agency is gathering health data at this time to develop Mississippi's "Health System Plan" (HSP). This is a five year plan which will identify the state's health care needs. An "Annual Implementation Plan" (AIP) will address how and when to meet those needs.

Laird states very emphatically his belief that no "Health Systems Plan" or "Annual Implementation Plan" can come about in Mississippi without heavy physician involvement. Both the HSP and AIP will be presented to technical advisory committees composed of physicians for their input.

The Mississippi Health Systems Agency, Inc. has 10 sub-area councils located throughout the state. These councils will eventually have initial review and approval authority over federal health care grant applications for facilities and services in their respective areas. The councils will conduct public hearings on these applications. The councils' recommendations on applications will be forwarded to the state Health Systems Agency.

Mississippi Health Systems Agency, Inc. has another priority during its first year of operation. It is to study and recommend the creation of more than one Health Systems Area and Health Systems Agency for Mississippi. Mississippi could have as many as four areas and agencies under present federal guidelines.

1977 MSMA-Robins Award Is Announced

The sixteenth annual Mississippi State Medical Association-Robins Award for outstanding community service by a state physician has been announced to the component medical societies by the Board of Trustees. The 1977 award will be presented at the 109th Annual Session during closing ceremonies on May 5.



MSMA-Robins Award

Dr. Lyne S. Gamble, president, and Dr. Robert Caldwell, chairman of the Board of Trustees, said that each component medical society has been invited to submit a nomination for the honor. The award is cosponsored annually by the association and the A. H. Robins Company of Richmond, Va., a long-established manufacturer of ethical pharmaceuticals.

Drs. Gamble and Caldwell said that nominees must be members of the state medical association and that the community service recognized by the local society's nomination must be apart from purely professional attainment, since suitable awards in this connection already exist.

Generally, the service by the physician-nominee should have benefitted the local or state communities in a civic, cultural, or general economic sense. It need not, however, have been a single achievement, since many outstanding citizens contribute to community betterment through a series of services in varying leadership roles.

Nominations should be made by letter, and there are no restrictions upon length or attached exhibits which assist in establishing the nominee's qualifications and record of achievement. Drs. Gamble and Caldwell said that each letter of nomination must be signed by an officer of the component medical society. Nominations from previous years may be resubmitted.

Deadline for submission of nominations to the state medical association is Jan. 1, 1977. Each nomination will be acknowledged, and the Board of Judges, consisting of the three MSMA vice presidents, will review the nominations.

The Robins series was instituted in 1962, and the award consists of a sculptured bronze plaque in bas-relief, engraved, and mounted on a mahogany panel.

The 15 Mississippi physicians who have received the high honor are Dr. Thomas G. Ross of Jackson, nominated by the Central Medical Society in 1962; Dr. Frank M. Davis of Corinth, by the Northeast Mississippi Medical Society in 1963; Dr. Howard A. Nelson of Greenwood, by the Delta Medical Society in 1964; and Dr. Maura J. Mitchell of Ellisville, by the South Mississippi Medical Society in 1965.

Dr. J. T. Davis of Corinth, by the Northeast Mississippi Medical Society in 1966; Dr. Frank M. Acree of Greenville, by Delta Medical in 1967; Dr. W. H. Anderson of Booneville by Northeast in 1968; Dr. Omar Simmons of Newton, by the East Mississippi Medical Society in 1969; Dr. W. J. Aycock of Calhoun City, by the Northeast Society in 1970; Dr. Walter H. Rose of Indianola, by Delta Medical in 1971; Dr. Reginald P. White of Meridian, by the East Mississippi Medical Society in 1972; Dr. W. A. Long, Jr., of Jackson, by the Central Medical Society in 1973; Dr. Virginia S. Tolbert of Ruleville, by Delta Medical Society in 1974; Dr. Thomas M. Davis of Jackson by Central Medical Society in 1975; and Dr. Thomas G. Barnes of Greenville, by Delta Medical Society in 1976.

Medical Auxiliary Helps With Flu Program



More than 80 physicians' wives in the Jackson area volunteered to help in Hinds County Health Department swine flu vaccination clinics. Discussing the clinic schedules with Hinds County Health Officer Dr. Eric McVey are from left, Dr. Mary Alice Lee, Health Officer; Mrs. William Bowlus; Mrs. Kermit Till; and Mrs. Doyle Smith. The members from Central Medical Auxiliary are working at the implied consent stations and assist with other clinic activities.

JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

VOLUME XVII

January-December, 1976

• EDITOR
W. Moncure Dabney, M.D.

• ASSOCIATE EDITORS
George H. Martin, M.D.
Myron W. Lockey, M.D.

• MANAGING EDITOR
Nola Gibson

• PUBLICATIONS COMMITTEE
Lawrence W. Long, M.D.
Chairman

Frank L. Butler, Jr., M.D.
T. A. Baines, M.D.
and the editors

• THE ASSOCIATION
Lyne S. Gamble, M.D.
President

James O. Gilmore, M.D.
President-elect

J. Elmer Nix, M.D.
Secretary-Treasurer

C. D. Taylor, Jr., M.D.
Speaker

R. Faser Triplett, M.D.
Vice Speaker

Charles L. Mathews
Executive Secretary

H. Cody Harrell
Assistant Executive Secretary and Comptroller

William F. Roberts, J.D.
Assistant Executive Secretary and Legal Counsel

Mississippi State Medical Association
735 Riverside Drive
Jackson 39216

The Journal of the Mississippi State Medical Association is owned and published by the Mississippi State Medical Association, founded December 15, 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216. Office of publication, 1201-05 Bluff Street, Fulton, Missouri 65251. Copyright 1976, Mississippi State Medical Association.

SUBJECT INDEX

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "N," News; "L," Letters to the Editor; "PP," President's Page; "RS," Radiologic Seminar; "BR," Book Review; "CPC," Clinicopathological Conference; "MLB," Medico-Legal Briefs; "AP," Auxiliary Page; the asterisk (*) indicates an original article in the JOURNAL, and the author's name follows the entry in brackets. "Deaths," "Personals," and "New Members" are indexed under the letters "D," "P," and "M" respectively.

Matter pertaining to MSMA is indexed under "Mississippi State Medical Association." For the author index see page 376.

A

Abdomen
Problems in Abdominal Surgery series:
I: peritoneovenous shunting for intractable ascites [Barnett] *5
II: postoperative reflux gastritis [Barnett] *67
III: severe dumping syndrome [Barnett] *132
IV: postoperative recurrent peptic ulcer [Barnett] *184
V: incisional hernia [Barnett] *266
VI: intestinal obstruction from peritoneal carcinomatosis [Barnett] *325
Alcoholism
female alcoholics studied at UMC, 140-N
Mississippi Baptist Medical Center opens chemical dependency unit, 282-N
UMC offers substance abuse clinics, 288-N
Allergic Reactions
to chocolate sought [Frazier] 279-L
American Board of Family Practice
announces next exam, 88-N
American Cancer Society
UMC researcher gets ACS fellowship, 87-N
American College of Chest Physicians
pulmonary medicine course planned, 290-N
American College of Physicians
disease mechanisms studied at Shreveport, 18-N
internists meet in October, 319-N
internists study infectious diseases, 89-N
Med Center hosts Mississippi-Louisiana ACP meet, 149-N
Medical Center hosts ACP course, 147-N
Mississippi-Louisiana internists meet, 30-N
American College of Radiology
position paper on mammographic examinations, 253-E
American College of Surgeons
care of acutely injured is studied, 343-N
American Heart Association
Dr. Guyton receives AHA research award, 22-N
May is national high blood pressure month, 141-N
support high blood pressure month [Lockey] 137-E
American Lung Association
physicians need to counsel smokers, 26-N
American Medical Association
physicians urge nursing home improvements, 344-N
Principles of Ethics permit advertising, 204-N
rural health is emphasized, 86-N
"The AMA Meeting in Dallas" [Gamble] 252-PP
Arrington, Lamar
is honored for 50 years of practice, 145-N
Arteriosclerosis
myocardial scanning in coronary artery disease [Markov et al] *61
Arthritis
outline of a treatment program for rheumatoid arthritis [Hunder] *129
Artz, Curtis P.
speaks at surgical forum, 149-N
Ascites
problems in abdominal surgery I:
peritoneovenous shunting for intractable ascites [Barnett] *5
Athletics
annual coast athletic injuries seminar held, 287-N
Atkinson, Jack A.
address of the president, *189
MSMA president appears on television, 180-N
Auxiliary to MSMA
annual session program, 106
helps with flu program, 366-N
page in JOURNAL, 363

B

Berman, Maxwell D.
family presents gifts to UMC, 140-N
Bicentennial
the bicentennial [Gibson] 16-E
Blastomycosis
recognition and management of [McGee et al] *347
Blue Cross-Blue Shield of Mississippi
Dr. E. M. Moffitt elected to Blues board, 180-N
Dr. S. H. McDonnieal is recognized, 180-N
Mississippi Blues announces building plans, 80-N
MSMA president appears on television, 180-N
Books Reviewed
Chusid, J. G.: Correlative Neuroanatomy and Functional Neurology—16th ed. [Haerer] 199-BR
Frazier, Claude A.: Annual Review of Allergy 1974 [Booth] 19-BR
Goldman, Mervin J.: Principles of Clinical Electrocardiography—9th ed. [Carmichael] 337-BR
Hilgard, Earnest R., and Hilgard, Josephine R.: Hypnosis in the Relief of Pain [Burgess] 199-BR
Karpman, Harold L.: Your Second Life [Giles] 51-BR
Kempe, C. Henry; Silver, Henry K.; and O'Brien, Donough: Current Pediatrics Diagnosis and Treatment—4th ed. [Freeman] 311-BR
Krupp, Marcus A., and Chatton, Milton J.: Current Medical Diagnosis and Treatment 1976 [Atkinson] 165-BR
Miller, Robert H. and Cantrell, James R.: Textbook of Basic Emergency Medicine [Christian] 283-BR
National Academy of Sciences: Genetic Screening: Programs, Principles and Research (Oelshlegel and Sullivan) 283-BR
Smith, Donald R.: General Urology—8th ed. [Carter] 19-BR
Smith, Robert R., and Robertson, James T.: Subarachnoid Hemorrhage and Cerebrovascular Spasm [Tutor] 123-BR
Bolten, Karl A.
is given posthumous award, 27-N
Boronow, Richard C.
coauthors book, 208-N

C

Cancer
cancer concepts 1976 set for October, 207-N
complete excision of skin cancers [Brock] *351
Mississippi hospitals chosen for cancer program, 23-N
Carcinoma
postirradiation carcinoma of the thyroid gland [Martin] 195-E
report of a case of clear-cell carcinoma of the vagina [Simmons] *306
Carcinomatosis
problems in abdominal surgery IV: intestinal obstruction from peritoneal carcinomatosis [Barnett] *325
Cardiology
echocardiography course planned, 208-N
what the internist should know about echocardiography [Glasser] *291
Cardiovascular Disease
Mississippi Baptist Medical Center sponsors second seminar, 288-N
what the internist should know about echocardiography [Glasser] *291
Carter, Jimmy
the new president and medicine [Dabney] 359-E
Central Medical Society
meets with solons, 82-N
Chiropractic
"Hands only" may be decided in court case [Jarmon] 315-N
MSMA files suit, 26-N
Cobb, Alton B.
receives new appointment, 84-N
Colon Disease
angiographic localization of bleeding diverticulosis of the colon: a case report [Russell and Marascalco] *328-RS
Comprehensive Health Planning, Division of
health planning designation brews, 86-N

Continuing Medical Education
"CME and the Good Physician" [Gamble] 334-PP
MSMA conducts physicians' CME survey, 59-N
MSMA stresses CME, 258-N
Colposcopy
colposcopic evaluation of the female lower genital tract [Swan] *181
Coronary Disease
myocardial scanning in coronary artery disease [Markov et al] *61

D

Deaths
Biles, G. Lacey, 316
Brown, William A., Jr., 255
Denson, Grover C., 197
Durfey, John R., Jr., 124
Ellis, Clyde A., 255
Fenstermacher, Richard H., 82
Hamrick, DeWitt, 256
Hand, William F., 364
Jarrett, Guy C., 168
Kimbriel, A. C., Jr., 316
Marland, Thomas J., 24
Mason, George S., 256
McKinnon, Joseph G., 52
Morris, L. B., 24
Mosley, Elmer W., 197
O'Mara, William E., 82
Overby, James A., 142
Peeler, Joseph G., Sr., 142
Pegram, Robert H., Jr., 124
Rayburn, Theodore H., 142
Robinson, Thomas A., 316
Vick, Walter D., 142
Dermatology
complete histological examination of excised skin cancers for adequacy of excision [Brock] *351
Diabetes
a review of the Mississippi PSRO screening criteria for diabetes mellitus, 44
juvenile diabetes board is announced, 342-N
Disabled Physicians Act
The Disabled Physicians Act in Mississippi [Dabney] 75-E
Diverticulosis
angiographic localization of bleeding diverticulosis of the colon: a case report [Russell and Marascalco] *328-RS
Dog Bites
reach epidemic proportions in U.S. [Blakey] 196-L
Drug Abuse
Mississippi Baptist Medical Center opens chemical dependency unit, 282-N
narcotics agents will aid in crime prevention, 314-N
UMC offers substance abuse clinics, 288-N
Drugs
Medicaid surveys pharmacy ownership, 314-N
Dumping Syndrome
problems in abdominal surgery III: severe dumping syndromes [Barnett] *132

E

Echocardiography
course planned, 208-N
what the internist should know about it [Glasser] *291
Education, Medical
are there too many medical schools?, 320-N
dramatic change occurs in medical education, 50-N
Electrocardiography
EKG course at UMC draws state physicians, 85-N
Emergency Medical Care Unit (EMCU)
opens at state capitol, 59-N
serves Mississippi legislators, 84-N
Emergency Medicine
the past, present, and future of emergency medical care in the state of Mississippi [Hopson] 15-E
ENT (See Otolaryngology)
management of head and neck tumor [Lockey] 49-E
modern temporal bone surgery [Gardner] *31
surgical treatment for vertigo [Gardner] *1
Ethics, Medical
AMA Principles of Ethics permit advertising, 204-N
Excerpta Medical Foundation
patient counselling congress set, 30-N

F

Family Practice
family medicine preceptorships at UMC funded, 59-N
family medicine review set, 203-N
Mississippi med students learn family practice, 146-N
UMC's first residents finish, 260-N
Family Practice Specialist
family medicine review set, 30-N
family physicians learn to be preceptors, 88-N

G

Gall Bladder
gallstone ileus: a case report [Sauls and Lowe] *70-RS
trans T-tube extraction of retained biliary stones [Hodges] *8-RS
Gastroenterology
problems in abdominal surgery II: postoperative reflux gastritis [Barnett] *67
Genetics
UMC hosts genetics workshops, 344-N
Guyton, Arthur C.
receives AHA research award, 22-N
Guyton Memorial Medical Education Loan Fund
trustees meet, 344-N
Gynecology
colposcopic evaluation of the female lower genital tract [Swan] *181
maternal and neonatal herpes infection [Dale] *261
report of a case of clear-cell carcinoma of the vagina [Simmons] *306

H

Health Care Costs
Ford proposes changes in health funding, 88-N
Health Care Delivery
NHI is in a lull, 28-N
Health Manpower
bill passes, 259-N
Health Systems Agency
health planning designation brews, 86-N
health planning potpourri, 201-N
HSA protest is filed, 258-N
HSAs board composition disclosed, 343-N
MHSA receives conditional approval, 287-N
MSMA endorses the MHIC, 29-N
Phil Laird reports on MHSA, 365-N
regional health planning: what to look for [Brooks] *271
status of implementation of P.L. 93-641 [Gamble] 308-PP
Heart
tri-state heart assembly planned, 84-N
Heart Disease
myocardial scanning in coronary artery disease [Markov et al] *61
Hernia
problems in abdominal surgery V: incisional hernia [Barnett] *266
Herpes Infection
editorial comment on scientific article [Sherline] 278-E
maternal and neonatal herpes infection [Dale] *261
Histology
complete examination of excised skin cancers for adequacy of excision [Brock] *351
Holiday Inn Downtown (Jackson)
is headquarters for MSMA 108th annual session, 81-N
Hopkins, L. G.
is new MHA president, 259-N
Hospitals
community hospital may not lease office to private physician, 29-MLB
Mississippi hospitals chosen for cancer program, 23-N
Hypertension
May is national high blood pressure month, 141-N
Mississippi has first statewide HBP program, 287-N
support high blood pressure month [Lockey] 137-E
UMC researcher gets hypertension grant, 318-N

I

Immunobiologic Agents
and drugs available from Center for Disease Control in Atlanta, 279-L
Immunology
UMC researcher studies immunotherapy protocols, 343-N
Infants, Newborn
maternal and neonatal herpes infection [Dale] *261
Infection
internists study infectious diseases, 89-N
maternal and neonatal herpes infection [Dale] *261
Influenza
identification of the flu virus is important, 318-N
MSMA auxiliary helps with program, 366-N
old vaccine on hand [Blakey] 310-L
Insecticides
organophosphate insecticide poisoning [Atkinson] *91
Insurance, Professional Liability
Mississippi premiums rise, 259-N
St. Paul explains rate increase [Holland] 310-L

Interstate Postgraduate Medical Association
scientific assembly scheduled, 208-N
Intestine
problems in abdominal surgery VI: intestinal obstruction from peritoneal carcinomatosis [Barnett] *325

J

Journal MSMA
history of medical publications in Mississippi [Gibson] *10
readership survey results are released [Gibson] 75-E
Juvenile Diabetes Foundation
greater Jackson chapter board is announced, 342-N

K

Kidney
medical center hosts seminar, 208-N
physicians study kidney disease at UMC, 206-N

L

Laboratory Sciences, Clinical
UMC lab gets Bac Tec system, 320-N
Laird, Phil
reports on MHSA, 365-N
Legislature
Central Medical Society meets with solons, 82-N
EMCU serves Mississippi legislators, 84-N
"Influencing Legislation" [Atkinson] 120-PP
"Legislation in 1977" [Gamble] 358-PP
MSMA president testifies before legislature, 84-N
new state administration begins, 57-N
the new president and medicine [Dabney] 359-E
state medical institutions face cuts, 58-N
Stennis proposes retirement tax relief, 89-N
"The Disabled Physicians Act" [Dabney] 75-E
Letters to the Editor
dogbites reach epidemic proportions in U. S. [Blakey] 196-L
mumps activity in schools [Blakey] 51-L
research on the Munchausen syndrome [Hyler] 336-L
scabies [Blakey] 139-L
Litigation
constructive new press policy praised, 318-N
countersuit filed against alleged discrimination, 315-N
"Hands only" may be decided in court case [Jarmon] 315-N
MSMA files suit against a chiropractor, 26-N
Liver
liver scanning in polycystic liver disease [Sanders and Flowers] *269-RS
Louisiana O and O Society
meets, 142-N
Lungs (See Pulmonary Disease)
a simple technique for performing bronchography [Moore] *303-RS
intermittent positive pressure breathing [Emory] *295
recognition and management of blastomycosis [McGee et al] *347
tri-state thoracic conference set, 28-N

M

Malpractice (See Litigation and Medico-Legal Briefs)
Mississippi professional liability premiums rise, 259-N
St. Paul explains rate increase [Holland] 310-L
Mammography
courses are offered, 144-N
courses are offered, 205-N
position paper on mammographic examination, 253-E
radiation dangers of [Martin] 309-E
Marijuana
Ole Miss pot is good stuff, 344-N
M*A*S*H
med center forum reunites M*A*S*H buddies, 145-N
McDonnieal, S. H., Jr.
is recognized by Blue Cross-Blue Shield, 180-N
Medicaid
announces drug cuts, 203-N
Ford proposes changes in health funding, 88-N
costs and controversy [Mathews] 336-E
MSMA reviews Medicaid practices, 60-N
surveys pharmacy ownership, 314-N
Medicare
changes are approved, 16-N
Medical Injury Compensation System
objectives of medical injury compensation system [Gamble] *194-PP
Medical History
a history of medical publications in Mississippi [Gibson] *10
MSMA: You're ten years older than you think! [Sturdivant] *330
You could have been a steam doctor [Campbell] *298
Medical Practice
physicians beware! medicine is being assaulted [Lockey] 335-E
the new president and medicine [Dabney] 359-E
unlicensed practice is charged, 362-N
Medicine and Religion
physicians and clergy workshop held at UMC, 58-N
Medico-Legal Briefs
both hospital and surgeon liable for nurses' negligence, 170-MLB
community hospital may not lease office to private physician, 29-MLB
Illinois physician wins countersuit, 278-MLB
malpractice panel's recommendation on liability barred at trial, 337-MLB
patient must arbitrate claim of negligence, 254-MLB
physician not liable for nurse's negligence in giving injection, 360-MLB
release of motorist no absolute bar to malpractice suit, 50-MLB
uphold validity of medical malpractice panels in N. Y., 196-MLB
$175,000 awarded to parents for outrageous conduct by hospital, 80-MLB
$275,000 for alleged negligence during hysterectomy, 138-MLB
Members, New
Atkinson, Bruce E., 20
Austin, William K., Jr., 76
Bailey, Terald O., 76
Ball, David Allen, 123
Barrett, H. S., Jr., 197
Bates, Gaylon M., 278
Becker, Karl E., 165
Blake, Thomas H., Jr., 279
Blumenthal, Bernard I., 279
Boone, Walter T., 364
Brantley, Nan, 165
Brantley, Terry K., 255
Buckley, Robert L., Jr., 76
Butani, Kanta P., 316
Byars, Wilton V., II, 279
Calvert, William E., 364
Carmichael, Benjamin M., 20
Cater, Robert J., 20
Chidester, Linda Fay, 20
Clark, William F., 279
Clay, Joseph V. F., Jr., 165
Collum, Julius, 54
Cooper, Edgar S., 76
Cranston, Philip Edwin, 279
Dahlke, Charles B., 279
Dale, Robert A., 255
Davis, William M., 364
DeGroote, J. W., 364
Dewey, Thomas J., 20
Dilworth, Robert Earle, 255
Draper, Edgar, 165
Fieselman, David W., 165
Fineburg, Steven B., 20
Fleckenstein, Loren D., 255
Fox, Claude Earl, III, 197
Freeman, Erwyn E., Jr., 123
Garner, Mabel T., 165
Godsey, John W., 364
Gough, Walter C., 20
Henry, D. Chan, 364
Hollingsworth, Jefferson F., 20
Howe, Michael, 279
Hudson, Starkey L., 255
Hughes, James L., 364
Jackson, John K., 123
Jones, Walter R., Jr., 279
Jordon, Covin M., Jr., 279
Kahlstorf, W. L., 76
Kellett, Boyd A., 20
Kelly, Roy A., Jr., 165
Kinsey, Herbert P., 255
Knutson, Richard A., 166
Kushner, Sheldon R., 54
Larkin, William B., Jr., 316
Longmire, A. W., 20
Lowe, Robert Ray, Jr., 364
Malone, William J., 166
Massey, Fred M., 20
McCarthy, Bruce M., 124
McClung, Lawson E., 54
McCrory, Henry Allen, 20
McGehee, Helen G., 166
McIlwain, James S., Jr., 255
McMillin, F. Lamar, Jr., 124
Meyer, William H., 197
Miles, Betty C., 166
Mitchell, Don Q., 124
Mitchell, Joseph R., 364
Morgan, M. G., 124
Morrison, Margaret H., 54
Nichols, Frank A., 54
Olivo, Marciano T., 138
Pendergrass, John L., 138
Pierce, Paul W., III, 54
Pyron, Katharine A., 197
Rennick, Ronald L., 76
Ricchetti, Warren F., 76
Sams, William C., III, 364
Sanford, Robert A., 364
Scallorn, Glenda J., 166
Seay, John David, 197

Shows, Billy Ray, 54
Simmons, William B., 20
Swanton, Joseph E., 255
Temple, Van H., 76
Thomas, David R., 166
Tipton, A. C., Jr., 255
Vogel, B. Frank, 76
Watkins, Charles, 255
Warren, Gene, 338
Welch, Paul B., 138
Westbrook, Terry E., 279
Wheelock, Mark C., 54
Wilburn, Frank W., 20
Wilkinson, Charles L., 54
Williams, Morris E., 54
Yamashiro, Emi, 364
Millsaps College
Dr. Harmon Smith speaks at Millsaps, 60-N
Mississippi Academy of Family Physicians
elects officers and holds annual meeting, 286-N
Mississippi Arts Festival
set for April, 90-N
Mississsippi Baptist Medical Center
opens chemical dependency unit, 282-N
sponsors second cardiovascular seminar, 288-N
Mississippi Bureau of Narcotics
agents will aid M.D.s in crime prevention, 314-N
Mississippi Foundation for Medical Care
a review of the Mississippi PSRO screening criteria for diabetes mellitus, 44
reports PSRO implementation, 86-N
Mississippi Health Improvement Corporation
endorsed by MSMA, 29-N
health planning designation brews, 86-N
health planning potpourri, 201-N
Mississippi Health Systems Agency
HSA board composition disclosed, 343-N
HSA protest is filed, 258-N
Phil Laird reports on, 365-N
receives conditional approval, 287-N
Mississippi Heart Association
Dr. L. G. Hopkins is new president, 259-N
May is national high blood pressure month, 141-N
support high blood pressure month [Lockey] 137-E
tri-state heart assembly planned, 84-N
Mississippi Lung Association
supports pulmonary fellows at UMC, 86-N
Mississippians participate in pediatric pulmonary course, 362-N
Mississippi Medicaid Commission
announces drug cuts, 203-N
costs and controversy [Mathews] 336-E
MSMA reviews Medicaid practices, 60-N
surveys pharmacy ownership, 314-N
Mississippi Medical Political Action Committee (MPAC)
MPAC bats .740, 26-N
Mississippi Public Health Association
holds 39th annual meeting in Jackson, 341-N
Mississippi Society for the Prevention of Blindness
reports on year's work, 202-N
Mississippi State Board of Health
discloses swine flu vaccination plans, 290-N
Dr. Alton Cobb receives new appointment, 84-N
Dr. Clyde Watkins assumes new TB post, 80-N
health planning designation brews, 86-N
identification of flu causes is important, 318-N
influenza vaccine [Blakey] 310-L
Mississippi has first statewide high blood pressure program, 287-N
Mississippi Public Health Association holds meeting in Jackson, 341-N
new State Board of Health appointees are announced, 60-N
Rocky Mounted Spotted Fever update, 206-N
the past, present, and future of emergency medical care in the state of Mississippi [Hopson] 15-E
Mississippi State Medical Association
Auxiliary—helps with flu program, 366-N; page in journal, 363
Board of Trustees—holds fall meeting, 21-N; conducts summer meeting, 285-N; names 1976-77 officers, 176-N
Central Medical Society—meets with solons, 82-N
Continuing Medical Education—MSMA conducts physicians' survey, 59-N; MSMA stresses CME, 258-N
Constitution and By-Laws, 243
Disabled Physician's Act [Dabney] 75-E
Emergency Medical Care Unit—opens at Capitol, 59-N; serves Mississippi legislators, 84-N
Fifty Year Club—Dr. Lamar Arrington is inducted, 145-N
Health Systems Agency—MSMA files protest, 258-N
History, Medical—MSMA: You're ten years older than you think! [Sturdivant] *330; and see JOURNAL MSMA
House of Delegates—proceedings of special session, 116; handbook for 108th Annual Session, 109; proceedings of 108th Annual Session, 211
JOURNAL MSMA—a history of medical publications in Mississippi [Gibson] *10; readership survey results are released, 75-E
Litigation—MSMA files suit against a chiropractor, 26-N; "Hands Only" may be decided in court case [Jarmon] 315-N
Mississippi Foundation for Medical Care—reports PSRO implementation, 86-N
Mississippi Health Improvement Corporation—endorsed by MSMA, 29-N
MPAC—bats .740, 26-N
Peer Review Committee—reviews Medicaid practices, 60-N
President of MSMA—Atkinson—address of the president, *189; testifies before legislature, 84-N; appears on television, 180-N; president's pages in JOURNAL: "Thoughts on the Health Care Scene," 14-PP; "The Credibility Gap," 48-PP; "Simple Solutions Don't Solve Complex Problems," 74-PP; "Influencing Legislation," 120-PP; "Some Things Do Not Change," 136-PP
President of MSMA—Gamble—praises constructive new press policy, 318-N; president's pages in JOURNAL: "Objectives of Medical Injury Compensation System," 194-PP; "The AMA Meeting in Dallas," 252-PP; "Health Care Regulation," 275-PP; "Status of Implementation of P.L. 93-641," 308-PP; "CME and the Good Physician," 334-PP; "Legislation in 1977," 358-PP
Professional Liability Insurance—Mississippi premiums rise, 259-N; St. Paul explains rate increase [Holland] 310-L
Robins Award for 1977 announced, 366-N
Rural Health—is emphasized, 86-N
108th Annual Session—official call and program, 95; returns to Jackson with headquarters at new Holiday Inn Downtown, 81-N; convention in Jackson, 162-PP; Mississippi Urological Society plans May 2 seminar, 23-N; MSMA sponsors annual session party to celebrate the bicentennial, 108-N; specialty societies hold concurrent meetings, 178-N; Dr. Lyne S. Gamble is inaugurated president and Dr. James O. Gilmore is named president-elect, 171-N; "Thoughts on Annual Session" [Dabney] 163-E
109th Annual Session—Council on Scientific Assembly begins planning, 257-N; scientific assembly begins work for '77, 176-N
Mississippi Thoracic Society
elects officers, 170-N
thoracic case conference held in Biloxi, 87-N
tri-state thoracic conference set, 28-N
Moffitt, Ellis M.
is elected to Blue Cross and Blue Shield of Mississippi board, 180-N
Mumps
activity in schools [Blakey] 51-L

N

National Cancer Institute
Mississippi hospitals chosen for cancer program, 23-N
National Health Insurance
can we afford national health insurance? [Dabney] 277-E
NHI is in lull, 28-N
National Health Planning and Resources Development Act of 1974
health care regulation [Gamble] 275-PP
HSAs board composition disclosed, 343-N
MHSA receives conditional approval, 287-N
Phil Laird reports on the MHSA, 365-N
public law 93-641 [Mathews] 309-E
regional health planning: what to look for [Brooks] *271
status of implementation of P.L. 93-641 [Gamble] 308-PP
Network for Continuing Medical Education
program schedule, 346
Neurology
computerized axial tomography [Douglas] *155
postgraduate course on the spine set, 60-N

practical modern neurology course set, 27-N
Neurosurgery
postgraduate course on the spine set, 60-N
Newborn Care (Neonatology)
maternal and neonatal herpes infection [Dale] *261
pulmonary overaeration in infancy [Blumenthal] *39-RS
UMC announces newborn center art contest, 89-N
New Orleans Graduate Medical Assembly
scheduled for March, 30-N
North Mississippi Medical Center
a review of management of patients with urinary stones [Elliott et al] *36
Nursing Homes
physicians urge improvement, 344-N
Nutrition
fast food fare gets good calorie rating, 168-N

O

Obstetrics
colposcopic evaluation of the female lower genital tract [Swan] *181
Dr. Sherline receives UMC award, 284-N
Dr. Wiser is new head of UMC ob-gyn department, 147-N
maternal and neonatal herpes infection [Dale] *261
Ophthalmology
Louisiana O and O society meets, 142-N
Organophosphates
insecticide poisoning [Atkinson] *91
Orthopaedic Surgery
idiopathic scoliosis [Yerger] *321
Otolaryngology
Louisiana O and O Society meets, 142-N
management of head and neck tumor [Lockey] 49-E
modern temporal bone surgery [Gardner] *31
surgical treatment for vertigo [Gardner] *1
Otology
modern temporal bone surgery [Gardner] *31

P

Patient, the
patient counselling congress set, 30-N
Pathology
anatomic pathology studied in Miami, 27-N
complete histological examination of excised skin cancers for adequacy of excision [Brock] *351
Pediatrics
echocardiography course planned, 208-N
Mississippians participate in pediatric pulmonary course, 362-N
pediatric intensive course held, 27-N
pulmonary overaeration in infancy [Blumenthal] *39-RS
the undescended testis [Hillis and Keeton] *151
Peptic Ulcer
problems in abdominal surgery IV: postoperative recurrent peptic ulcer [Barnett] *184
Personals
Abangan, Rolando T., 360
Abernethy, Lynn D., 77
Adkins, Jerry R., 256
Ahmed, Afzal, 280
Amell, Juan R., 280
Andy, O. J., 18
Applewhite, Robert Rex, 360
Arens, James F., 18, 77
Arrington, George L., Jr., 54, 77, 167
Arrington, M. L., 18
Atkinson, Jack A., 18, 54
Aycock, Larry B., 312
Bailey, S. L., 167
Baird, Frank Jewell, 138, 281
Baker, Robert Neil, 54
Balaski, J. Phillip, 280
Ball, George, 280
Ball, Leonard D., 360
Barnes, Helen B., 18
Barnett, Jim C., 281
Barnett, William O., 77, 167
Bass, James C., Jr., 138, 312
Becker, Jasper B., Jr., 281
Bellamy, H. Maynard, Jr., 340
Benefield, Thomas, 311
Bennett, Kenneth R., 54
Benoist, Louis A., 311
Bernfield, Helen C., 77
Billups, William A., Jr., 360
Blake, Thomas H., Jr., 138
Blanton, Terrell D., 281
Blaylock, Darrell N., 280
Bledsoe, Robert E., 281
Blount, Richard L., 77, 197
Boelens, Peter A., 340
Boggan, Austin P., 54
Bolton, Eldon L., 360
Bomboy, David W., 280
Boronow, Richard C., 77, 340
Bosio, Bruner B., 280
Bower, John D., 54, 167
Bowlin, John W., 280
Braddock, T. N., 55
Bradford, William W., 256, 311
Bramlett, Eugene V., 18
Brantley, Nan, 167
Breland, Loren D., 360
Briseno, Oscar J., 256
Britton, A. B., Jr., 198
Brock, Ralph L., 312
Brooks, Michael, 280
Brown, Ronald L., 361
Bruce, James A., 54
Brumby, Paul B., 77, 167
Buckley, Robert L., 139, 280
Buckley, Theresa L. R., 77, 122
Burgess, Duane, 54
Burnett, William J., 167
Burrow, Harry E., 18
Burrow, Nancy W., 78
Busey, John F., 197
Bush, Charles A., 198
Butani, Kanta, 197
Byarlay, John, 256
Byars, W. Vance, II, 281
Caccamise, Charles, 18
Caldwell, D. R., 77
Calhoun, William F., 77
Campbell, Guy, 54
Campbell, Joe, 167
Carlson, David I., 311
Carmichael, Benjamin M., 340
Carey, Tom, 312
Carr, William J., Jr., 311
Carter, Robert Frank, 361
Casey, Michael R., 280
Cater, Robert, 77, 167
Cates, Robert T., 122
Chavez, Carlos M., 122
Chevis, Sidney A., 256
Christman, J. Eric, 280
Clark, Howard, 198
Clay, John, 167
Clippinger, David, 311
Cobb, Robert L., 280
Cockrell, Marion E., 18
Coggin, Robert L., 311
Conerly, A. Wallace, 54, 360
Conn, Francis R., 340
Cooper, Tom S., 280
Courtney, John W., 311
Covington, Joe S., 312
Crawford, Benjamin, 197
Crawford, Benjamin, III, 280
Crawford, Everett, 197
Crawford, Walter, 197
Cronin, Irvin H., 77
Cronin, Kenneth I., 77
Currier, Robert D., 55
Dabbs, O. D., Jr., 311
Dale, David, 281
Davis, John Robert, 122
Davis, J. T., 198
Davis, Woody, 340
DeBerardinis, Michael, 280
Dement, Frank, 361
Derrick, Arthur A., 311
Dewey, Thomas J., 256, 280
Diaz, Albert L., 122
Dill, A. Robert, 281
Dodson, Marion L., 280
Donald, Robert L., Jr., 167
Dudley, William H. C., Jr., 256
Duncan, Roy D., 311
Eckford, J. F., 18, 198
Ederington, John, 18
Edwards, John Berlyn, 280
Edwards, Paul E., Jr., 340
Elliott, John P., 122
Ellis, Bernard H., Sr., 280
Emerson, Charles W., 280
Evans, John, 18
Evans, John W., 139
Evans, S. R., Jr., 139
Fabian, Judy, 77
Farber, Louis A., 77
Ferguson, James V., Jr., 256
Feurst, S. I., 122
Flechas, Enrique, 122
Flores, Tomas R., 256
Flowers, William M., Jr., 139
Floyd, Bedford F., 256
Floyd, Charles N., 340
Fox, C. E., III, 18
Freeman, Howard G., Jr., 77
Friedman, Cherie, 55
Fuller, Richard, 139
Fuller, Robert P., 167
Gabel, Joseph C., 77, 167
Gamble, Lyne S., 198, 312
Ganaraj, P. S., 197, 281
Gandy, Thomas, 139
Garrott, Thomas C., 280
Gates, William C., 77
Gibson, John Y., 55
Giles, Hannelore H., 281
Giles, W. G., 256, 280
Gillis, W. R., 77
Gilmore, James O., 311
Gleaves, James R., 77
Goel, Dinesh, 280
Goff, Barbara, 167
Goode, Paul, 197

Goodman, Henry Brown, 311
Gorton, W. M., 340
Gough, Walter C., 340
Gowan, Hugh Lee, 281
Gray, Robert, 122
Green, James, 167
Griffing, J. C., 55
Guess, Charles D., 122
Haerer, Armin F., 340
Hagaman, A. Van Dyke, 198
Hagood, Clyde O., Jr., 340
Hall, Toxey E., 340
Hamilton, George C., Jr., 167
Hammack, Leslie, 340
Hand, William L., 256
Hardy, James D., 18
Harrison, William, 55
Hatten, Karl, 18
Hatten, Lewis Edwin, 360
Heitzman, Harry Brad, 55
Henderson, J. L., 122, 311
Herndon, Caleb W., 256, 312
Henry, D. Chan, 122
Hinman, M. E., 18, 139
Hodges, Lucien, 361
Hogue, Charles, 256
Holcomb, Barry W., 281
Holder, Ernest J., 138
Hollingshead, Charles A., 280
Hollis, Richard S., 280
Holloman, G. H., 312
Holmes, Wendell, 139
Hoover, Jack C., 55, 77
Hopkins, L. Gerald, 167
Hopson, W. Briggs, Jr., 18, 312
House, Jefferson Davis, 281
Howard, A. B., 280
Hudson, Harold K., 77
Hughes, James Langston, Jr., 122
Hughes, William L., 198
Hutchinson, C. M., 256
Jabaley, Michael E., 167
Jackson, A. C., Jr., 340
Jackson, William, 256
Jackson, William, 312
Jaquith, W. L., 122, 198
Jenkins, Charles R., 198
Johnson, Cleve E., 138
Johnson, Dwight A., 77
Johnston, Joseph E., 122
Jorasen, James A., 340
Karathanasis, Demetra, 280
Keel, Daniel T., Jr., 139
Kelly, Roy A., Jr., 340
Kepner, Sewall, 55
Killelea, Donald E., 77
King, Jack, 55
Kitchens, Ben E., 122
Lane, Dewey H., 18, 167, 340
Langston, Ledon, 280
Lauderdale, James A., Jr., 54
Lee, H. M., 55
Leggett, Frank, 77, 256
Lehmann, Louis C., 312
Lipscomb, Lewis D., 197
Little, Robert Ashford, 139
Lobrano, William B. C., 122
Lockey, Myron W., 77
Love, S. Kimble, 122
Lovelace, John R., 312
Lubritz, Ronald R., 167
Lyle, Russell Ray, 55
Malonzo, Aida A., 360
Mann, John E., 122
Marascalco, Charles, 18
Martin, B. B., 122
Martin, James B., 122
Martinolich, Andrew K., 361
May, Robert O., 77
Mayer, William T., 312
McCollum, Charles R., 256
McDonnell, W. F., Jr., 198, 256
McGehee, Helen, 18
McLain, James, 197
McLeod, James N., 197
McMahan, Lynn B., 281
McMillan, Fred, 77
McMullan, George K., Jr., 281
McMullan, Martin H., 340
McNeil, Jack A., 281
McPherson, Frank, 18
McQuinn, William C., 167
McRae, Maury, 55
Merrell, W. H., 167, 256
Miles, Charles D., 361
Mitchell, J. Daniel, 198
Mitchell, Robert A., 311
Mitchell, Tom H., 18, 77, 312
Monaco, Benjamin, 77
Moore, Paul H., 281
Morgan, John D., 54, 312
Morris, Larry B., 78
Morris, Toxey M., 281
Morrison, Francis S., 77, 122, 167, 256, 340, 361
Murray, John P., 281
Nassar, J. G., 77
Nelson, Norman C., 122
Nichols, Frank A., 280
Nicholls, Richard A., 312
Norman, Joe R., 54, 55, 167
North, Ed, 198
Oakes, W. T., 167
Owen, David, 18
Pace, Brantley B., 340
Page, Matthew J., 312
Pandey, Shanti, 55
Pankratz, David C., 77
Parker, Charles R., 77
Pate, S. Ray, 167
Patrick, Bernard S., 139
Pineda, Mario R., 167, 340
Porter, John A., 312
Powell, Kenneth E., 167
Price, E. J., 280
Purohit, Ramesh C., 340
Purohit, S. K., 281
Purser, Thomas, III, 361
Purvis, George D., 312
Rawson, John E., 77
Rayner, Donald R., 77
Rayner, James W., 54
Reed, John E., Jr., 281
Reed, Kenneth N., 167
Reynolds, Ernest D., 139
Riemann, E. T., Jr., 311
Riley, Richard, 167
Risher, Lindsey, 77
Ritter, Robert M., 281
Robinson, Jo N., 198
Robinson, William B., 361
Rogers, Lee, 122
Ross, Joe, 18
Rubenstein, Louis A., 122
Russwurm, Dale, 281
Sams, James H., 77, 167, 281
Sanders, John R., 281
Sandifer, Fred M., III, 312
Santangelo, Anthony J., 167
Scanlon, Leo J., 55
Schuster, Richard E., 78
Scott, Edward G., 55
Selman, Francis J., Jr., 311, 361
Senter, Jack, 122
Shands, Thomas A., 78
Shaw, G. Boyd, 54
Sheffield, James A., 311
Sheffield, Thomas E., 281
Sherline, Donald M., 55, 198, 340
Simmons, Susan, 281
Simmons, W. C., 55
Simpson, Tommy T., 55
Sloan, Robert D., 55
Smith, Bennett E., Jr., 139, 361
Smith, George V., 54
Smith, Gerald, 167
Smith, McKamy, 198
Smith, Perrin, 198
Smith, Prentiss, 139
Smith, Robert Allen, 281
Smith, Shelby, 312
Sneed, Ralph, 281
Soriano, Augustus P., 78
Spears, Dalton E., 78
Spell, James P., 139
Springer, Joseph G., Jr., 167
Stauss, Hans-Karl, 18
Stevens, Thomas E., 122
Stewart, Edsel F., 139
Stewart, Ray, 198
Stewart, W. K., 361
Strong, James E., Jr., 256
Stubblefield, Earle T., 281
Suber, Barry D., 281
Suess, James F., 78
Sumners, William E., 312
Swanton, Joseph E., 361
Talmor, Hanoch, 281
Taylor, C. D., 198
Taylor, Walter, 167
Thigpen, Tate, 198
Thomas, Douglas F., 281
Thompson, Will, 167
Thornhill, David Henry, 312, 361
Thornton, Dan R., Jr., 361
Tillman, Clifford, 281
Toler, Mert, 18
Towler, Howell, 55
Trapp, James, 122
Treadwell, Walter, 256, 340
Tucker, E. W., 312
Turner, Thomas C., 197
Tutor, E. G., 281
Valenzuela, Raul E., 78, 167
Vise, Guy T., Jr., 122
Waldron, W. L., 168
Walker, Joe, 122
Watkins, Clyde A., 18
Watson, Victor D., 122
Weems, W. Lamar, 168, 256
Wesson, Ray L., 256
Wesson, Thomas W., 312
Westbrook, Terry E., 168
Wharton, George W., 122
Wicker, Ralph T., 78
Wiener, Julian, 340
Wilcox, W. Paul, 78
Wilkerson, George E., 256
Wilkes, Thurston E., II, 281
Williams, Cecil T., Jr., 139, 256
Williams, John Clark, 139
Williams, Ronald B., 78, 281
Williamson, Stoney, 281
Williford, James S., 122, 256, 280
Wilson, John Knox, 168
Wilson, William B., 167
Wimberly, John A., 281
Wiygul, Frank, Jr., 18
Wofford, J. L., 256
Wofford, John D., 280
Woodbridge, Hardy B., 78
Wright, Dennis I., 198
Yates, Allen R., 256
Yawn, Victor W., 122

Yong-Min, Chi, 197
Young, W. D., 198
Young, W. Russell, 281
Pharmacy
Medicaid surveys pharmacy ownership, 314-N
Physicians
CME and the good physician [Gamble] 334-PP
physicians beware! medicine is being assaulted [Lockey] 335-E
physicians urge nursing home improvements, 344-N
still lead public confidence polls, 170-N
Poisoning
organophosphate insecticide poisoning [Atkinson] *91
Postgraduate Calendar
schedules published on pages 17, 55, 78, 139, 164, 200, 312, 333, 361
Press, the
MSMA president praises constructive new press policy, 318-N
Psychiatry
emotional problems management course offered, 90-N
Publications, Medical
a history of medical publications in Mississippi [Gibson] *10
readership survey results released [Gibson] 75-E
Professional Liability Insurance
Mississippi premiums rise, 259-N
St. Paul explains rate increase [Holland] 310-L
Professional Standards Review Organization
a review of the Mississippi PSRO screening criteria for diabetes mellitus, 44
MFMC reports PSRO implementation, 86-N
receives good report, 198-N
Pulmonary Disease (See Lungs)
acute pulmonary medicine featured at UMC, 203-N
course planned, 290-N
lung association supports pulmonary fellows, 86-N
Mississippians participate in pediatric pulmonary course, 362-N
pulmonary course held at UMC, 205-N
pulmonary overaeration in infancy [Blumenthal] *39-RS
the recognition and management of Blastomycosis [McGee et al] *347

R

Radiologic Seminars
CLVIII: trans t-tube extraction of retained biliary stones [Hodges] *8-RS
CLIX: pulmonary overaeration in infancy [Blumenthal] *39-RS
CLX: gallstone ileus—a case report [Sauls and Lowe] *70-RS
CLXI: intravenous voiding cystourethrography [Keel] *187-RS
CLXII: liver scanning in polycystic liver disease [Sanders and Flowers] *269-RS
CLXIII: a simple technique for performing bronchography [Moore] *303-RS
CLXIV: angiographic localization of bleeding diverticulosis of the colon [Russell and Marascalco] *328-RS
CLXV: the passing of the general radiologist [Sloan] *355-RS
Radiology (See Radiologic Seminars)
computerized axial tomography [Douglas] *155
mammography courses are offered, 144-N
myocardial scanning in coronary artery disease [Markov et al] *61
position paper on mammographic examinations, 253-E
postirradiation carcinoma of the thyroid gland [Martin] 195-E
radiation dangers of mammography [Martin] 309-E
xeromammography [Martin] 121-E
Regional Health Planning
what to look for [Brooks] *271
Respiratory Disease (See Pulmonary Disease)
intermittent positive pressure breathing [Emory] *295
Rheumatoid Arthritis
outline of a treatment program for [Hunder] *129
Rocky Mountain Spotted Fever
updated, 206-N

S

Scabies
scabies [Blakey] 139-L
Scoliosis
idiopathic scoliosis [Yerger] *321
Sherline, Donald M.
receives UMC ob-gyn award, 284-N
Smith, Harmon L.
speaks at Millsaps College, 60-N
Smoking
physicans need to counsel smokers, 26-N
Social Security Administration
actuary explains deficits, 282-N
South Central Association of Blood Banks
meets in 1976, 90-N
Southeastern Surgical Congress
set for New Orleans, 89-N
Spine, the
postgraduate course set, 60-N
St. Dominic Hospital
medical staff officers announced, 82-N
Stings, insect
can be fatal, 207-N
Stomach
problems in abdominal surgery II: postoperative reflux gastritis [Barnett] *67
Stones, urinary
a review of the patients with urinary stones at North Mississippi Medical Center [Elliott et al] *36
St. Paul Insurance Company
explains rate increase [Holland] 310-L
Mississippi professional liability premiums rise, 259-N
Surgery (See Problems in Abdominal Surgery Series, Urology, ENT, and Orthopaedic Surgery)
Dr. Curtis Artz speaks at surgical forum, 149-N
Southeastern Surgical Congress set, 89-N
surgeons attend third surgical forum, 144-N
surgical treatment for vertigo [Gardner] *1
UMC surgical forum is March 11-13, 85-N
vascular surgery course planned, 346-N
Swine Flu
medical auxiliary helps with flu program, 366-N
SBH discloses vaccination plans, 290-N
Syphilis
1976 CDC recommended treatment schedules, 191

T

Taxes
Stennis proposes retirement tax relief, 89-N
Testis, the
the undescended testis [Hillis and Keeton] *151
Thoracic
thoracic case conference held in Biloxi, 87-N
tri-state thoracic conference set, 28-N
Thyroid Gland
postirradiation carcinoma of the thyroid gland [Martin] 195-E
Tomography
computerized axial tomography [Douglas] *155
Trauma
care of acutely injured studied, 343-N
the past, present, and future of emergency medical care in the state of Mississippi [Hopson] 15-E
Tuberculosis
Dr. Clyde Watkins assumes new SBH TB post, 80-N
Tumors
management of head and neck tumor [Lockey] 49-E

U

Ulcer
problems in adbominal surgery IV: postoperative recurrent peptic ulcer [Barnett] *184
U.S. Public Health Service
Mississippi Public Health Association holds meeting in Jackson, 341-N
University of Mississippi
Ole Miss pot is good stuff, 344-N
University of Mississippi Medical Center (UMC)
acute pulmonary medicine featured, 203-N
adds two faculty members, 320-N
announces faculty promotions, 290-N
announces newborn center art contest, 89-N
announces new faculty members, 204-N
continues record enrollment, 342-N
Dr. Berman's family presents gifts, 140-N
Dr. Bolten is given posthumous award, 27-N
Dr. Curtis Artz speaks at surgical forum, 149-N
Dr. Guyton receives AHA research award, 22-N
Dr. Holmes is top UMC med student, 202-N
Dr. Sherline receives ob-gyn award, 284-N
Dr. W. H. Stewart will address commencement, 146-N
Dr. Wiser is new head of ob-gyn department, 147-N
EKG course draws state physicians, 85-N

faculty member gets fellowship, 319-N
family medicine preceptorships funded, 59-N
family physicians learn to be preceptors, 88-N
female alcoholics studied, 140-N
first family practice residents finish, 260-N
gains faculty members, 342-N
Guyton loan fund trustees meet, 344-N
has new faculty members, 288-N
health manpower bill passes, 259-N
hosts ACP course, 147-N
hosts genetics workshop, 344-N
infectious diseases studied, 22-N
juniors begin 48-week curriculum, 149-N
lab gets Bac Tec system, 320-N
lung association supports pulmonary fellows, 86-N
med center forum reunites M*A*S*H buddies, 145-N
med center hosts Mississippi-Louisiana ACP meet, 149-N
medical center announces new staff, 24-N
medical center awards 115 M.D. degrees, 201-N
medical center has visiting faculty, 87-N
medical center hosts kidney seminar, 208-N
Mississippi hospitals chosen for cancer program, 23-N
Mississippi med students learn family practice, 146-N
Mississippi, Louisiana internists meet, 30-N
most UMC house staff are from in-state, 258-N
new class enrolls in School of Medicine, 290-N
offers substance abuse clinics, 288-N
pediatric intensive course held, 27-N
physicians and clergy workshop held, 58-N
physicians study kidney disease, 206-N
pulmonary course held, 205-N
receives Mississippi Chemical Co. grant, 260-N
researcher gets hypertension grant, 318-N
researcher studies immunotherapy protocols, 343-N
shock is studied, 147-N
state medical institutions face cuts, 58-N
surgeons attend third surgical forum, 144-N
surgical forum is March 11-13, 85-N
three UMC med students study in Nepal, 205-N
UMC faculty member coauthors book, 208-N
UMC graduate gets 2 degrees, 202-N
UMC researcher gets ACS fellowship, 87-N

Urology

a review of management of patients with urinary stones at North Mississippi Medical Center [Elliott et al] *36
Mississippi Urological Society plans May 2 seminar, 23-N
intravenous voiding cystourethrography [Keel] *187-RS
the undescended testis [Hillis and Keeton] *151

V

Vaccination

influenza vaccine [Blakey] 310-L
SBH announces swine flu vaccination plans, 290-N

Vagina

report of case of clear-cell carcinoma of the vagina [Simmons] *306

Vascular Disease

vascular surgery course planned, 346-N

Venereal Disease

1976 CDC recommended treatment schedules for syphilis, 191

Vertigo

surgical treatment for [Gardner] *1

Virgin Islands

clinical conference set, 29-N

W

Watkins, Clyde

assumes new SBH TB post, 80-N

Wiser, Winfred

is new head of ob-gyn department at UMC, 147-N

X

Xeromammography

xeromammography [Martin] 121-E

AUTHOR INDEX

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "N," News; "L," Letters to the Editor; "PP," President's Page; "RS," Radiologic Seminar; "MLB," Medico-Legal Briefs; "BR," Book Review; "AP," Auxiliary Page. The asterisk (*) indicates an original article in the Journal.

A

Atkinson, Bruce, *91, 165-BR
Atkinson, Jack A., 14-PP, 48-PP, 74-PP, 120-PP, 136-PP, *189

B

Barnett, William O., *5, *67, *132, *184, *266, *325
Blakey, Durward L., 51-L, 139-L, 196-L, 279-L, 310-L
Blumenthal, Bernard I., *39-RS
Booth, Bernard H., 19-BR
Brock, Jim M., *351
Brooks, Thomas J., III, *271
Burgess, C. Duane, 199-BR

C

Campbell, Guy D., *347
Campbell, Leslie Caine, *298
Carmichael, Benjamin M., 337-BR
Carter, Robert F., Jr., 19-BR
Christian, Ronnie S., 283-BR

D

Dabney, W. Moncure, 75-E, 163-E, 277-E, 359-E
Dale, Robert A., Jr., *261
Douglas, Michal A., *155

E

Elliott, John P., Jr., *36
Emory, W. Brooks, *295
Evans, John W., *36

F

Flowers, W. Mel, Jr., *269-RS
Frazier, Claude A., 279-L
Freeman, Erwyn E., Jr., 311-BR

G

Gamble, Lyne S., 162-PP, 194-PP, 252-PP, 275-PP, 308-PP, 334-PP, 358-PP
Gardner, Gale, *1, *31
Gibson, Nola, *10, 16-E, 75-E
Giles, Hannelore, 51-BR
Glasser, Stephen P., *291
Gordon, James O., *36
Griffin, Jerry C., *61

H

Haerer, A. F., 199-BR
Hellems, Harper K., *61
Hillis, R. S., *151
Hodges, Jeff, *8-RS
Holland, J. D., 310-L
Hopson, W. Briggs, Jr., 15-E
Hunder, Gene G., *129
Hyler, S. E., 336-L

J

Jarmon, Kathy, 315-N

K

Keel, Dan T., *187-RS
Keeton, J. E., *151

L

Lehan, Patrick H., *61
Lockey, Myron W., 49-E, 137-E, 253-E, 335-E
Lowe, C. Foster, *70-RS

M

Marascalco, Charles A., *328-RS
Markov, Angel K., *61
Martin, George H., 121-E, 195-E, 309-E
Mathews, Charles L., 50-E, 309-E, 336-E
McGee, George E., *347
Moore, Paul H., *303-RS

O

Oelshlegel, Fred, Jr., 284-BR

P

Platt, Lucas, *36

R

Rodriguez, Gaston, *61
Russell, Jerry T., *328-RS

S

Sanders, Jane A., *269-RS
Sauls, Jeffrey L., *70-RS
Sherline, Donald M., 278-E
Simmons, Walter H., *306
Sloan, Robert D., *355
Smith, Robert O., *61
Sturdivant, Laura D. S., *330
Sullivan, Donna C., 284-BR
Swan, Robert W., *181

T

Tutor, Forrest T., 123-BR

W

Williams, Hamp D., *347

Y

Yerger, Buford, Jr., *321

TABLE OF PAGES

January	1 to 30	July	181 to 210	Transactions of the House of Delegates	211 to 242
February	31 to 60	August	211 to 260		
March	61 to 90	September	261 to 290		
April	91 to 128	October	291 to 320		
May	129 to 150	November	321 to 346	Constitution and By-Laws of the Association	243 to 251
June	151 to 180	December	347 to 376		

CLASSIFIED

TAX DEDUCTIBLE VACATIONS FOR MEDICAL PROFESSIONALS. Over 500 listings of national/international meetings in the medical sciences for 1977. Send a $10 check or money order payable to Professional Calendars, P.O. Box 40083, Washington, D.C. 20016.

JOIN MPAC TODAY

PRINTING — OFFICE SUPPLIES

EQUIPMENT — FURNITURE



Premier Printing Company

2485 West Capitol Jackson, Mississippi

Phone 352-4091

Index to Advertisers

Beltone Electronics Corp. 17
Burroughs Wellcome Co. 6B

Canton Exchange Bank 10
Coca-Cola 10

Hill Crest Hospital 16
Hyrex-Key Pharmaceuticals 4
Humana, Inc. 11

Eli Lilly and Co. front cover

Mead Johnson Laboratories 8

Pennwalt Prescription Products 362B, 362C, 362D
Pharmaceutical Manufacturers Assoc. 14B, 15

Premier Printing Co. 19
Professional Calendars 19

Riverside Hospital 12
A. H. Robins Co. 10A, 10B
Roche Laboratories
second cover, 3, 354B, 354C, 354D, third and fourth covers
Roerig and Co. 14A

Sheraton-Biloxi 7
Smith Kline and French 354A

Warner-Chilcott Labs 6, 6A

Thomas Yates and Co. 18

IN CONCLUSION

Professional liability insurance problems continue to plague not just the medical profession, but nearly every professional segment of society: St. Paul Fire and Marine Insurance Co. announced it will issue only claims-made malpractice insurance policies for lawyers. Architects have become the latest professional victims of deeper-pocket jurisprudence. Some firms have been wiped out by massive judgments and high premiums. A Conn. university is being sued for educational malpractice by a student claiming she learned nothing from a required course.

You can do more for your health by not smoking than you can by paying exorbitant hospital and doctor bills after you get sick, reports Stanford Research Institute. Dr. J. H. Chadwick, director of health systems at SRI, says that behavior and lifestyle have more effect on national health than does medical care delivered after illness strikes. For this reason, he says, much of SRI's research is directed toward care that can be provided outside the hospital or clinic to subjects who are not yet ill.

Seven colleges or technical schools in five states have been granted accreditation of their medical assisting programs by the AMA Council on Medical Education, in collaboration with the Curriculum Review Board of the American Association of Medical Assistants. These additions bring the total of accredited programs to 116 in 28 states. Accredited post-secondary-level programs provide basic knowledge of administrative, laboratory and clinical procedures. Subjects studied include anatomy, physiology, law and ethics, human relations, insurance, and bookkeeping.

Direct pressure on physicians and hospitals to keep health care prices down should be exerted by large corporations and labor unions. This is the message of a report released by the Council on Wage and Price Stability, the government's inflation watchdog agency. W. Lilley, agency's director, said that the private sector must participate more aggressively because government-sponsored programs have not proved effective and listed examples in which pressure by firms and unions ultimately had been successful in curbing medical costs.

A Division of Drug Misuse study of drug treatment data has indicated that most Mississippians seeking drug treatment are misusers of marijuana followed closely by barbiturate and other sedative misusers. The recently-completed summary of drug treatment data from across the state reveals major drugs of misuse and the areas of the state in which they are frequently found as determined by the number of persons seeking drug treatment. Data also revealed that the greatest number of people seeking treatment are white (80.2%) and male (62.4%).

THE ANXIETY-SPECIFIC.

- a predictable pattern of patient response
- seldom associated with serious side effects, in proper dosage
- rarely interferes with mental acuity
- used concomitantly with many primary medications
- three dosage strengths meet most patient needs

LIBRIUM® ℞

chlordiazepoxide HCl/Roche

5mg, 10mg, 25mg capsules

Libritabs® (chlordiazepoxide) available in 5 mg, 10 mg and 25 mg tablets.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules,* 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets,* 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, New Jersey 07110

Please see following page.

THE ANXIETY-SPECIFIC

Since its discovery in the research laboratories at Roche, Librium has been the object of ongoing pharmacologic and clinical investigation.

The published record on Librium is enormous. So large, in fact, we put it into a computer literature retrieval system to make it more accessible in answering your inquiries.*

It's a record that reveals a consistent pattern of patient response. A highly favorable benefits-to-risk ratio. And minimal interference with many primary medications.

Doing one thing well. Basically, that's what Librium is all about.

LIBRIUM® Ⓘⓥ
chlordiazepoxide HCl/Roche

LIBRARY
JAN 4 1977
NEW YORK ACADEMY OF MEDICINE



ROCHE

*If you have a question about Librium or any other Roche product, write to Professional Services, Roche Laboratories, Nutley, New Jersey 07110.

Please see preceding page for a summary of product information.

N.Y. ACADEMY OF MED
EAST 103RD ST
NEW YORK N.Y.

The New York Academy of Medicine

DUE IN 4 WEEKS UNLESS RENEWED
NOT RENEWABLE AFTER 8 WEEKS

DATE BORROWED	BORROWER